### AGENDA

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>No</th>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB14-15/0043</td>
<td>1.</td>
<td>2.00pm</td>
<td>PRELIMINARY BUSINESS (Acting Chair – Dr P Naylor)</td>
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<td>1.1 Apologies for Absence</td>
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<td>1.2 Chair's Announcements</td>
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<td>1.3 Declarations of Interest</td>
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<td>1.4 Comments/questions from members of the public</td>
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<td>1.5 Patient Story (Lorna Quigley)</td>
<td>Presentation</td>
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<td>1.6 Minutes and Action Points of Last Meeting – held on 7th</td>
<td>DRAFT GB Minutes</td>
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<td></td>
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<td></td>
<td>October 2014 (All)</td>
<td>DRAFT Action Points</td>
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<td>• Action Points</td>
<td>PUBLIC MEETING 07 1of WCCG - PUBLIC GB †</td>
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<td>1.7 Matters Arising</td>
<td>To note amendments</td>
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<td>• Procedures of low clinical priority</td>
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<td>GB 14-15/0044</td>
<td>2.</td>
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<td>ITEMS FOR APPROVAL</td>
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<td></td>
<td>2.1 Proposed amendments to NHS Wirral CCG's Constitution (Paul</td>
<td>Constitution cover</td>
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<td></td>
<td></td>
<td>Edwards)</td>
<td>CCG Constitution final sheet template November draft - MASTER VERSI</td>
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<td>Constitutional implications of the rev</td>
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<td>GB 14-15/0045</td>
<td>3.</td>
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<td>ITEMS FOR DISCUSSION</td>
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<td>GB 14-15/0046</td>
<td>4.</td>
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<td>ITEMS FOR INFORMATION</td>
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<td>4.1 Quality Performance and Finance- QPF (Lorna Quigley/Mark Bakewell)</td>
<td>Integrated Performance and Finance And presentation</td>
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<td>5.</td>
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<td>ITEMS FOR NOTING</td>
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<td>5.1 Subgroups (Ratified Minutes):</td>
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<td></td>
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<td>• WHCC of: 16.07.2014</td>
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<td>• QPF of: 30.09.2014</td>
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</tbody>
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6. RISK REGISTER

Current Risk Register

- Risk Register - November GB 1.pdf

7. ANY OTHER BUSINESS

7.1

8. End

DATE AND TIME OF NEXT MEETING

Tuesday 2nd December 2014
2pm – 4pm
Nightingale Room OMH

Please forward any apologies to Allison.hayes@nhs.net

**Latest submission date for papers is Friday 21st November 2014**

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Wirral Clinical Commissioning Group – Future Meetings 2014

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
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<tbody>
<tr>
<td>Tuesday</td>
<td>2nd December</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
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<tr>
<td>Tuesday</td>
<td>6th January</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
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</table>
Minutes of Meeting – Public Session
Tuesday 7th October 2014
2pm
Nightingale Room, Old Market House

Present:

Jon Develing (JD)    Interim Accountable Officer
Dr P Naylor (PN)    Acting Chair WCCG
Mark Bakewell (MB)  Chief Finance Officer
Lorna Quigley (LQ)  Head of Quality and Performance
Dr M Green (MG)    Consortium Chair
Dr H McKay (HM)    GP Executive (WGPCc)
Dr A Ali (AA)      GP Executive (WGPCc)
Iain Stewart (IS)  Consortium Chief Officer (WACC)
Christine Campbell (CC)  Consortium Chief Officer (WGPCc)
Dr J Oates (JO)    Consortium Chair
Dr D Jones (DJ)    GP Executive (WHCC)
Andrew Cooper (AC)  Consortium Chief Officer (WHCC)
Paul Edwards (PE)  Head of Corporate Affairs
Dr S Wells (Swe)   Acting Chair (WHCC)
Graham Hodkinson (GH)  Director of DASS
Dr A Smethurst (AS)  Secondary Care Doctor
Simon Wagener (SW)  Lay member patient champion

In Attendance:

Allison Hayes (AJH)  Executive Assistant
Richard Williams (RW)  LMC Representative
Sarah Quinn (SQ)  Commissioning Manager

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
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<tbody>
<tr>
<td>GB14-15/0037</td>
<td>Preliminary Business</td>
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<tr>
<td></td>
<td>1.1 Apologies for absence</td>
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<tr>
<td></td>
<td>Apologies were received from: James Kay, Fiona Johnstone and Karen Prior.</td>
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<tr>
<td></td>
<td>1.2 Chairs Announcements</td>
</tr>
<tr>
<td></td>
<td>Chair welcomed all members to the meeting. 2 members of the public attended the meeting.</td>
</tr>
<tr>
<td></td>
<td>1.3 Declarations of Interest</td>
</tr>
<tr>
<td></td>
<td>PN stated that he was involved with work with NICE in an area not related to the item on Procedures of Low Clinical Priority. This was therefore a declaration, and not a conflict of interest.</td>
</tr>
<tr>
<td></td>
<td>All members declared an interest in the item on the Constitution, as the paper directly refers to the Governing Body and its members.</td>
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</table>
1.4 Comments/questions from members of the public

There were no comments or questions from members of the public.

1.5 Patient Story

LQ gave an overview of a patient’s story which highlighted the importance of how the NHS works as a system within various departments. It highlighted the importance of respecting a patient’s wishes with regards to their treatment.

SWe commented on how important integration and communication with the wider public is, and all members agreed.

Members noted the contents of the patient story.

1.6 Minutes from previous meeting held on 2nd September 2014.

The minutes of the previous meeting held on 2nd September 2014 were agreed as a true and accurate record notwithstanding grammatical/typographical errors which will be rectified. There were no matters arising.

*Action Points – please refer to separate Action Sheet.*

2.0 Items for approval

2.1 Procedure of Low Clinical Priority

SWe gave an overview of the Procedure of Low Clinical Priority report. The purpose of this report is to:

- Provide an overview of the process undertaken to update the Commissioning Policies which included: a review of clinical evidence, public consultation and equality impact assessment. It was highlighted that for exceptional cases independent funding requests are available.
- Present the final policy to the Governing Body for approval

Particular areas of discussion included: subfertility, Varicose Veins, Penile Implants and Diabetes/Continuous Glucose monitoring, complementary therapies and circumcision. Some of these areas may be subject to further review in due course.

The Governing Body were asked to consider whether the CCG should adopt and put into practice the updated policy but with the recommended exceptions and amendments.

Chair gave thanks to Dr Wells and the Clinical Strategy Group for their work

GB agreed to adopt NICE guidelines regarding subfertility which includes offering 3 cycles of IVF up to age 40, 1 cycle age 40-42 and some provision for same sex couples.

MG queried the possible position where other CCGs may not adopt the same stance as Wirral CCG. PE assured members that Wirral CCG has followed NICE guidelines and those CCGs who had not done so, would need to explain their rationale as part of their Governing Body deliberations.

DJ sought clarity regarding the policy for Childlessness. SWe clarified that there is no current guidance in relation to the definition of childlessness available. JD suggested that the CCG
continue with the current definition of childlessness.

SW highlighted the need to consider a timescale and mechanism to review all policies and PE clarified that there would need to be a regular global review process, but individual areas would be reviewed on a case by case basis when there was a significant change in NICE guidance or other significant change in local factors. PE also explained that, if adopted, the CCG would develop an implementation process for making sure these procedures were built into contracts of current providers.

The Governing Body noted the report presented today and agreed the proposed direction of travel to implement NICE Guidelines as outlined in the report. Members also agreed to adopt the current definition of Childlessness.

2.2 Emergency Preparedness, Response and Resilience

PE gave an overview of the Emergency Preparedness Response and Resilience plans and processes of the CCG and the requirement to self-assess compliance with core standards. PE talked members through the standards, the evidence of compliance and the action plan. Members agreed to self-assess as ‘green which is fully compliant.

SW suggested that public engagement should be considered and that the public are assured that the CCG have robust plans in place.

The Governing Body noted and agreed the EPRR self-assessment rating and PE will submit to the NHS England Area Team.

3.0 Items for Discussion

3.1 NHS Wirral CCG Response to the Capability and Governance Review & Constitutional Implications

JD provided members with an update regarding the NHS England Capability and Governance Review.

NHS England’s ‘Capability and Governance Review’ in relation to NHS Wirral CCG has made a number of key recommendations and these have been fully accepted by the CCG. As a result, a high level action plan has been developed in response and this is included here together with the Review summary issued by NHS England.

A number of the recommendations directly relate to the CCG’s constitution and a significant degree of change is required to that document to address the concerns highlighted by the Review.

In line with the guidance from NHS England entitled ‘Procedures for Clinical Commissioning Group Constitution Change, Merger or Dissolution’ (May 2013), the CCG has an opportunity to update its constitution at two yearly submission dates and is currently aiming to submit a revised constitution at the next submission date in November 2014.

The report presents an overview of proposed key changes to the constitution in response to the Review and it is envisaged that the full revised constitution will be presented to November 2014 Governing Body.

Recommendations aimed at strengthening the CCG and addressing the issues raised include:

- To improve its leadership and development of the whole system strategy
- To improve its delivery of A&E and urgent care
- To improve relationships with stakeholders
To improve its Governing Body capability
To improve governance
To improve its senior leadership capability

The CCG has developed a high level action plan that addresses each of these recommendations and also acknowledges that the CCG has already made significant progress in these areas.

Next steps
A more detailed action plan, with timescales, will be developed and the process for amending the CCG constitution will continue in line with NHS England guidance.

The Governing Body were asked to note the action plan in response to the recommendation of the ‘Capability and Governance Review’.

Constitutional Implications

JD gave an overview of the proposed amendments to the CCGs constitution.

The purpose of the report is to outline the constitutional implications arising from the Capability and Governance Review.

In addressing the fundamental problems resulting from the consortia and governance arrangements highlighted by the review, there are number of areas that require immediate change:
- Methods for determining clinical leaders
- Governing Body Composition
- Membership and clinical engagement methods
- Governance arrangements

In addition to the evidence provided from the CCG 360 degree survey, LMC survey of members and the review itself, the CCG has utilised a number of sources to inform the amendments
- Other ‘best practice’ constitutions
- NHS England advice
- Member practice engagement events
- GP Consortia forums
- Patient Forums
- Local Medical Committee
- CCG staff briefings and feedback

The constitutional amendments are a result of careful and considerate engagement and reflective of the urgent need for change. It is now recommended that these are incorporated into a revised constitution for consideration by the CCG Governing Body and submission to NHS England.

JD gave thanks to Governing Body members and the LMC for their work in supporting the direction of travel of the CCG.

GH commented positively on the features of the proposed constitution and highlighted the importance of engaging in new ways of working.

AA commented on how comprehensive the proposed amendments are and that there had been compromise to incorporate differing member practice views. He sought clarity as how the CCG could ensure member practices are assured that all appointment and election processes that are carried out are open, fair and transparent. JD assured AA that the CCG would be open and collaborative in these processes. AA concluded that the prime objective is to be successful and that the CCG would receive his full support. JO also stated that the proposals represented a
good compromise of member views.

SWWe agreed with AA and stated that there is evidence that concerns that have been raised have been listened to; however the CCG will support those seeking for further support and consultation.

RW thanked the CCG for their recent level of engagement with LMC and how the amendments to the constitution are being received by its members.

HM commented on the robust processes of appointments and the transparent nature required to fulfil these.

SW informed members of comments made by James Kay and sought clarity as to how GP practices vote for Governing Body members. He went on to suggest how the CCG need to communicate to its patients on a wider perspective in relation to any amendments made to the constitution. PN clarified the voting process for members.

DJ commented on how practices need to be considered in the involvement of developing the future of the CCG on an on-going basis.

JD reiterated the need for strong governance mechanisms and how the CCG can help members understand the election, voting and appointment processes. JD reminded members that NHS England will be required to ‘assure’ the process.

PN thanked the management team and the LMC for their work and gave thanks to JD for his work and support.

The Governing Body supported the proposed direction of travel of the CCG.

4.0 Items for Information

4.1 Quality Performance and Finance Report

Quality Performance

LQ gave a presentation on the activity performance for month 4 (July) and highlighted the positive areas and the improvements in the challenges that were originally presented.

Areas included:

- Family and friends
- NWAS turnaround
- Delivering the same sex accommodation
- Diagnostic test
- MRSA
- Referral to treatment – NHS Constitution 4 hour target
- Health Care Associated Infection

LQ also highlighted the CCG achievements as detailed in the Health Outcomes Framework.

The Governing Body noted the contents of the Quality and Performance Report.

Finance Report

MB provided information of the Financial performance against budgeted allocation for 2014/15 as at month 5 (August).
2014/15 Key Planning Requirements

1% Surplus - £4.68m
- 2.5% Headroom (non-recurrent resources) - £11.4m
- Minimum 0.5% Contingency
- CCG hold £3m vs £2.2m (0.5%)
- Better Payment Practice Code
- Cash Management

Year to Date (Month 5) Financial Performance

Planned Year to Date surplus – (£1.95m)
Current Year to Date surplus – (£1.24m)

Key Issues

- WUTH Contract position - (£1.7m) under @ M4 vs (£1.05m) @ M3 (£1.7m) @ M2
- Other NHS Providers – notably Royal Liverpool and Broadgreen (£0.42m) over
- Commissioned Out of Hospital - £0.678m (in month increase in CHC/package costs)
- Prescribing £0.16m over performance (in moth improvement £0.1m)
- QIPP Gap 5/12 - £2.6m (of £6.3m)

Forecast Outturn 2014/15

Forecast Assumptions

- Planned Forecast Surplus - £ 4.68m (1%) – remains deliverable but not without risk an
- Risks remain consistent with plan around main expenditure areas
- WUTH (variation away from outturn as per QIPP assumptions)
- Prescribing,
- Commissioned Out of Hospital Care,
- QIPP Gap
- YTD position reflect challenges of forecast delivery

Other Issues

- Hosting Arrangements
  - Discussions held with Cheshire & Merseyside Commissioning Support Unit with regards
to ceasing of arrangements relating to Isle of Man commissioner and use of CCG Ledger
  - Continuing Healthcare Restitution
  - New Guidance suggests future financial year top-slice to support national shortfall on risk
share basis

The Governing Body noted the financial report as at month 5 (August).

AS sought clarity regarding any shortfalls that the CCG may meet and the need to focus on how
the CCG deals with these.

4.2 Progress Report re: System Resilience Plan

AC provided an overview of the System Resilience Plan and introduced Sarah Quinn,
Commissioning Manager who went on to explain the details of the paper.
Work undertaken to date has secured £2.4 million system resilience funding from NHS England
and the paper provided a summary of progress to date with the development of the Wirral
System Resilience Group and Operational Resilience and Capacity Plan.

The next steps include:
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|         | • Continue to develop the system resilience group and implement the work plan  
|         | • Continue to develop the operational resilience and capacity plan as this work plan is progressed  
|         | • Work with providers to implement and monitor system resilience schemes |

The CCG Governing Body was asked to note the progress to date with the development of the system resilience group and operational resilience and capacity plan.

HM thanked SQ, AC and LQ for their work in relation to the plan.

### 4.3 Progress Report re: BCF (Better Care Fund)

SQ informed members of the current progress of the Better Care Fund. The paper summarised the current progress with the development of the Better Care Fund, and provides all the latest papers submitted to NHS England for the September submission giving a summary of initial feedback from the national BCF assurance team.

Formal feedback on the Wirral BCF submission is expected from NHS England by the end of October 2014.

The CCG and Council commissioning teams are working on an implementation plan and with Vision 2018 Programme leads to ensure that the programmes and projects are set up and monitored via the new Programme Management Office.

MB highlighted to the group the importance of the risk of non-delivery of performance targets.

GH commented on the achievement of integrated working relationships and the high level of ambition to achieve the targets set out.

The full document is to be circulated to members at a later date.

The CCG Governing Body noted the current progress regarding the Wirral Better Care Fund Proposals.

### 4.4 Progress Report re: Continuing Health Care (CHC)

IS provided members with a current progress report in relation to Continuing Health Care. The paper presented updated the Governing Body on recent key operational decisions taken by the management team to address current service matters and follows on from the issue identified in the Quality, Performance & Finance Committee on 26th August 2014 and subsequently included in the CSU Service Level Agreement update provided to Governing Body meeting on 2nd September 2014.

Key concerns include:

- Backlog of annual reviews (which increases the risk of safeguarding matters arising due to lack of updated clinical assessment and financial implications of care package costs)
- Performance reporting not adequate to inform the commissioner of key aspects of the service
- Speed of response in relation to patient queries about CHC eligibility decision-making and subsequent quality of complaint response letter content.

CC sought clarity around how the CCG are currently monitoring the action plan set out by the CSU and IS explained the current process.
GH suggested that forward planning is required to meet the demand being presented in related to care packages.

SWe highlighted the quality and risk implications to patients care and in summary JD suggested that a weekly report is to be provided to the Ops team and also on a monthly basis to the Quality, Performance and Finance Committee. Members were asked to note the accompanying letter to Leigh Griffin, Managing Director of the CSU, outlining the timescales for transition, including staff transfer to the new arrangements by 31st January 2015.

The Governing Body were asked to note the operational decision taken by the management team and the current direction of travel.

5.0 Items for Noting

5.1 Conflicts of Interest Policy

PE presented the Conflicts of Interest Policy to the group. The existing policy was approved by the Governing Body in March 2013. While the principles described within the policy have not changed there is a need to update it to reflect the changes in structure and personnel that have been implemented since its approval. The Terms of Reference for the Approvals Committee have also been updated and are amended within this policy.

The Governing Body noted the policy presented today.

5.2 Vision 2018 Update

Members noted the contents of the bulletin provided at today’s meeting.

5.3 Commissioning Plan/Commissioning Intentions

Members noted the commissioning plan presented at today’s meeting.

5.4 Subgroups (ratified minutes for noting)

- WGPCC of 11.06.2014
- Approvals Meeting of 27.08.2014
- Audit Meeting of 28.05.2014

The Governing Body noted the reports of the above subgroups.

6.0 Risk Register

PE gave an overview of the current risk register and all items were reviewed and noted today. It was agreed to increase the risk ratings in relation to the financial position.

7.0 Any other Business

There were no other items of business. Chair thanked members for their attendance.

The Board meeting ended at 16:15pm.

8.0 Date and Time of Next Meeting

The date and time of the next meeting is Tuesday 11th November 2014 in the Nightingale Room, OMH please contact Allison.hayes@nhs.net with any apologies or agenda items.

Board meeting ended at: 16:15pm
Wirral Clinical Commissioning Group

Governing Body

Draft Action Points re Meeting of 7th October 2014 (Public Session)
Duncan Room, OMH
2pm

Outstanding Actions from: 2nd September 2014

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<th>Topics Discussed</th>
<th>Minute</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
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New Actions from: 7th October 2014

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<th>Topics Discussed</th>
<th>Minute</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
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<tbody>
<tr>
<td>Minutes and Action Points of the last meeting</td>
<td>●</td>
<td>AJH/PE to rectify grammatical errors</td>
<td>AJH</td>
<td>11.11.2014</td>
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<tr>
<td>Procedures of Low Clinical Priority</td>
<td>2.1</td>
<td>CCG staff to work with providers to incorporate new policies into contracts</td>
<td>Contract leads</td>
<td>ongoing</td>
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<tr>
<td>Emergency Preparedness, Response and Resilience</td>
<td>2.2</td>
<td>PE to submit self-assessment</td>
<td>PE</td>
<td>ASAP</td>
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<td>Constitutional Implications</td>
<td>3.1</td>
<td>JD to bring full draft constitution to November Governing Body together with impact assessment</td>
<td>JD</td>
<td>11.11.2014</td>
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<tr>
<td>Continuing Health Care</td>
<td>4.4</td>
<td>IS to bring back a fuller more detailed report to November Governing Body</td>
<td>IS</td>
<td>11.11.2014</td>
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</table>
The date of the next meeting is Tuesday 11th November 2014 at OMH, Duncan Room. 
Agenda items and apologies are to be sent to: Allison.hayes@nhs.net
### Proposed amendments to NHS Wirral CCG’s Constitution

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>2.1</th>
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<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body</td>
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<tr>
<td>Reference:</td>
<td>GB14-15/0044</td>
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<tr>
<td>Meeting Date:</td>
<td>11th November 2014</td>
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**Lead Officer:** Paul Edwards, Head of Corporate Affairs

**Contributors:**

#### Governance:

<table>
<thead>
<tr>
<th>Link to Commissioning Strategy</th>
<th>To be a high performance, high reputation organisation with ambition.</th>
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<tbody>
<tr>
<td></td>
<td>To reduce waste and inefficiency and duplication within the patient journey and between partners.</td>
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<tr>
<td>Link to current governing body Objectives</td>
<td>To ensure that the CCG is a fully constituted organisation, in order to undertake fully its statutory requirements</td>
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**Summary:**

NHS England’s ‘Capability and Governance Review’ in relation to NHS Wirral CCG has made a number of key recommendations and these have been fully accepted by the CCG.

A number of the recommendations directly relate to the CCG’s constitution and a significant degree of change is required to that document to address the concerns highlighted by the Review. An overview of these proposed changes was presented to the Governing Body in October 2014 and were supported by members (attached as Appendix 1).

In line with the guidance from NHS England entitled ‘Procedures for Clinical Commissioning Group Constitution Change, Merger or Dissolution’ (May 2013), the CCG has an opportunity to update its constitution and is now presenting the full version of the amended Constitution to Governing Body, having also taken a legal opinion on the proposed amendments. In addition, in line with this guidance, the CCG has engaged with stakeholders, patients and member practices as part of the required Impact Assessment process.

These amendments will result in changes to the both the clinical and managerial infrastructure of the CCG and these are presented for information (attached as Appendix 2). It should be noted that the CCG has consulted with staff about the proposed structural changes in line with its Organisational Change policy.

**Recommendation:** To Approve

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<tr>
<th>To Note</th>
<th>Comments</th>
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<tr>
<td>To Approve</td>
<td>X</td>
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WCCG Governing Body Meeting 11.11.2014
| **Next Steps:** | Submit amended Constitution to NHS England for approval |
This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.

<table>
<thead>
<tr>
<th><strong>What are the implications for the following</strong> (please state if not applicable):</th>
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<tbody>
<tr>
<td><strong>Financial</strong></td>
<td>The CCG Constitution describes the Quality, Performance and Finance Committee and its role in overseeing financial performance and this will be retained as part of the Constitutional amendment process.</td>
</tr>
<tr>
<td><strong>Value For Money</strong></td>
<td>The Capability and Governance Review highlights the need to improve the effective use of staffing resources by moving to a more cohesive, single Wirral structure and this is reflected in the revised Constitution. The CCG Constitution describes the functions of the CCG, including ensuring robust financial stewardship and efficient services and this will be retained as part of the Constitutional amendment process.</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>The CCG Constitution ensures that the CCG is a fully constituted organisation, in order to undertake fully its statutory requirements. In addressing the concerns of the review, the Constitutional amendments should improve organisational stability and mitigate risk through a single planning and delivery process.</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>The CCG Constitution outlines how the CCG carries out its statutory duties. The process for amendment includes consideration of the requirement for legal advice and the CCG has sought legal that has confirmed that the proposed amendments comply with relevant legal requirements.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>The response to the Capability Review and the amended Constitution requires changes to the CCG’s staffing structures and these are being implemented in line with the CCG’s Organisational Change policy and utilising appropriate consultation.</td>
</tr>
<tr>
<td><strong>Equality &amp; Human Rights</strong></td>
<td>The impact assessment required by NHS England will be completed as part of the application process.</td>
</tr>
<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
<td>The impact assessment required for constitutional change includes patient involvement and this is being undertaken as part of the development of the amended constitution.</td>
</tr>
<tr>
<td><strong>Partnership Working</strong></td>
<td>The CCG Constitution describes that membership of the Governing Body and other committees. These include representation from partner organisations such as Wirral Local Authority and Healthwatch. The amendments have been shared with stakeholders such as Wirral Local Authority and Provider organisations, patient groups and on the CCG website.</td>
</tr>
<tr>
<td><strong>Performance Indicators</strong></td>
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</tr>
</tbody>
</table>

Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)*

[✓]
This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path i.e. other papers that are directly related to the current paper under discussion.

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<tr>
<td>Changes to the CCG Constitution</td>
<td>GB13-14/014</td>
<td>Governing Body</td>
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Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.
NHS WIRRAL
CLINICAL COMMISSIONING GROUP

CONSTITUTION
FINAL

Version: 1.6

NHS England Effective Date: [    ]
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FOREWORD

The Health and Social Care Act (2012) proposes to give General Practice Clinical Commissioning Groups responsibility for improving the population’s health and the power to do this by moving commissioning and resource allocation decisions as close to the patient as possible. NHS Wirral Clinical Commissioning Group (CCG) has been established in accordance with the Health and Social Care Act (2012) and is made up of local GP practices serving a population of around 330,000 across the Wirral.

Clinical Commissioning Groups are different from any other predecessor NHS organisation. It is the GP practices within Wirral that make up the membership of our organisation, which has a key role in the responsibility to deliver the best possible outcomes for the local population.

This constitution sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for the people to whom it is accountable. It describes the governing principles, rules and procedures that the CCG will establish to ensure probity and accountability in the day to day running of the clinical commissioning Group; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to its commissioning decisions.

The Constitution applies to all of the member practices; the Group’s employees, individuals working on behalf of the Group and to anyone who is a member of the Group’s Governing Body (including the Governing Body’s committees). These people are responsible for knowing, complying with and upholding the arrangements for the governance and operation of the Group as described in this constitution.

We plan to build on those things we have learnt and value from the past and to work with our partners on the significant challenges we face. In doing this we will ensure that the views of clinicians, local people and partner agencies inform all that we do. Real partnership will form an important part of how we deliver on our vision to:

“Improve health and reduce disease, by working with patients, public and partners, tackling health inequalities and helping people to take care of themselves.”
INTRODUCTION AND COMMENCEMENT

1.1. Name
1.1.1. The name of this Clinical Commissioning Group is NHS Wirral Clinical Commissioning Group hereinafter referred to as the Group.

1.2. Statutory Framework
1.2.1. Clinical Commissioning Groups are established under the Health and Social Care Act 2012 (“the 2012 Act”). They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 (“the 2006 Act”). The duties of clinical commissioning Groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.

1.2.2. NHS England is responsible for determining applications from prospective Groups to be established as clinical commissioning Groups and undertakes an annual assessment of each established Group. It has powers to intervene in a clinical commissioning Group where it is satisfied that a Group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.

1.2.3. Clinical commissioning Groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning Group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.

1.3. Status of this Constitution
1.3.1. This constitution is made between the members of NHS Wirral Clinical Commissioning Group and has effect from April 1st, 2013, when NHS England established the Group. The constitution will be published on the Group’s website at www.wirralccg.nhs.uk

1.3.2. Hard copies are available upon request for inspection from CCG headquarters Old Market House, Hamilton St, Birkenhead. CH41 5FL and all GP surgeries in Wirral. The document is available in other languages and formats if required as detailed in the publication policy.

---

1 See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act
2 See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
3 Duties of clinical commissioning Groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
4 See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
5 See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
6 See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
7 See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
8 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act
1.4. Amendment and Variation of this Constitution

1.4.1. This constitution can only be varied in two circumstances.⑨

a) where the Group applies to NHS England and that application is granted;

b) where in the circumstances set out in legislation NHS England varies the Group’s constitution other than on application by the Group

2. AREA COVERED

2.1. The geographical area covered by NHS Wirral Clinical Commissioning Group is the Borough of Wirral.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The following practices comprise the members of NHS Wirral Clinical Commissioning Group:

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<tr>
<th>PRACTICE</th>
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<tbody>
<tr>
<td>All Day Health Centre</td>
<td>Arrowe Park Hospital, Arrowe Park Road, Upton, CH49 5PE</td>
</tr>
<tr>
<td>Allport Surgery N85003</td>
<td>43 Bridle Road, Bromborough, CH62 6EE</td>
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<tr>
<td>Blackheath Medical Centre N85648</td>
<td>76 Reeds Lane, Leasowe CH46 1SG</td>
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<tr>
<td>Cavendish Medical Centre N85017</td>
<td>Birkenhead Medical Building, 31 Laird Street, Birkenhead, Wirral CH41 8DB</td>
</tr>
<tr>
<td>Central Park Medical Centre N85027</td>
<td>Victoria Central Health Centre, Mill Lane Wallasey CH44 5UF</td>
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<td>Church Road Medical Practice N85633</td>
<td>Higher Bebington Health Centre, 25 Brackenwood Road, Higher Bebington, Wirral CH63 2LR</td>
</tr>
<tr>
<td>Civic Medical Centre N85006</td>
<td>Civic Way, Bebington, Wirral, CH63 7RX</td>
</tr>
<tr>
<td>Claughton Medical Centre N85044</td>
<td>161 Park Road North, Claughton, Birkenhead, Wirral CH41 0DD</td>
</tr>
<tr>
<td>Commonfield Road Surgery N85009</td>
<td>156 Commonfield Road, Woodchurch, Wirral CH49 7LP</td>
</tr>
<tr>
<td>Devaney Medical Centre N85015</td>
<td>40 Balls Road, Oxton, Birkenhead, Wirral CH43 5RE</td>
</tr>
<tr>
<td>Earlston &amp; Seabank Medical Centre</td>
<td>1 Earlston Road</td>
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⑨ See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
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<td>N85619 Eastham Group Practice N85005</td>
<td>Tree Tops Primary Health Care Centre, 47 Bridle Road, Bromborough, CH62 6EE</td>
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<td>N85629 Egremont Medical Centre</td>
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<tr>
<td>N85029 Fender Way Health Centre</td>
<td>Fender Way, Beechwood, Wirral CH43 9QS</td>
</tr>
<tr>
<td>N85053 Field Road Health Centre</td>
<td>Field Road, Wallasey CH45 5BG</td>
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<tr>
<td>N85031 Gladstone Medical Centre</td>
<td>241-243 Old Chester Road, Birkenhead, Wirral, CH42 3TD</td>
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<tr>
<td>N85032 Greasby Group Practice N85032</td>
<td>Greasby Primary Care Centre, Greasby Road, Greasby, CH49 3AT</td>
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<td>N85041 Greenway Surgery N85041</td>
<td>1st Floor, Wing 4, St Catherine’s Health Centre, Church Road, Birkenhead, CH42 0LQ</td>
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<td>N85037 Heatherlands Medical Centre N85037</td>
<td>New Hey Road, Woodchurch, Wirral, CH49 9DA</td>
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<td>N85007 Heswall &amp; Pensby Group Practice N85007</td>
<td>270 Telegraph Road, Heswall, CH60 7SG</td>
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<td>N85022 Holmlands Medical Centre N85022</td>
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<td>N85059 Hoylake &amp; Meols Medical Centre N85059</td>
<td>Warwick House, Station Approach, Meols, CH47 8XA</td>
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<td>N85046 Hoylake Road Medical Centre N85046</td>
<td>314 Hoylake Road, Moreton, Wirral CH46 6DE</td>
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<td>N85054 Kings Lane Medical Practice N85054</td>
<td>Higher Bebington Health Centre, 25 Brackenwood Road, Wirral CH63 2LR</td>
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<td>N85640 Leasowe Primary Care Centre N85640</td>
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<td>N85616 Liscard Group Practice N85616</td>
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<td>N85023 Manor Health Centre N85023</td>
<td>Liscard Village Wallasey CH45 4JG</td>
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<td>N85002 Marine Lake Medical Practice N85002</td>
<td>The Concourse, Grange Road, West Kirby, CH48 4HZ</td>
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<td>N85625 Miriam Medical Centre N85625</td>
<td>Birkenhead Medical Building 31 Laird Street, Birkenhead, Wirral CH41 8DB</td>
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<td>N85615 Moreton Cross Group Practice N85615</td>
<td>Pasture Road Health Centre, Pasture Road, Moreton,</td>
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<td>N85028</td>
<td>Wirral CH46 8SA</td>
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<td>Moreton Health Clinic N85040</td>
<td>8 – 14 Chadwick Street Moreton, Wirral CH46 7XA</td>
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<td>Moreton Medical Centre N85048</td>
<td>27 Upton Road, Moreton, Wirral CH46 0PE</td>
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<td>Parkfield Medical Centre (H) N85034</td>
<td>Sefton Road, New Ferry, Wirral CH62 5HS</td>
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<td>Parkfield Medical Centre (R) N85051</td>
<td>Sefton Road, New Ferry, Wirral CH62 5HS</td>
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<tr>
<td>Prenton Medical Centre N85643</td>
<td>516 – 518 Woodchurch Road, Prenton, Wirral CH43 0TS</td>
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<tr>
<td>Riverside Surgery N85016</td>
<td>525 New Chester Road, Birkenhead, Wirral CH42 2AG</td>
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<tr>
<td>Silverdale Medical Centre N85058</td>
<td>Mount Avenue, Heswall, CH60 4RH</td>
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<td>Somerville Medical Centre N85024</td>
<td>69 Gorsey Lane Wallasey CH44 4AA</td>
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<td>Spital Surgery N85617</td>
<td>1 Lancelyn Court Precinct, Spital Road Bebington, Wirral CH63 9JP</td>
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<tr>
<td>St George’s Medical Centre N85012</td>
<td>Field Road Wallasey CH45 5LN</td>
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<td>St Hilary Group Practice N85025</td>
<td>Broadway Wallasey Wirral CH45 3NA</td>
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<td>66/68 Teehey Lane, Bebington, CH63 2JN</td>
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<tr>
<td>TG Medical Centre N85001</td>
<td>56-60 Grange Road, West Kirby, CH48 4EG</td>
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<td>The Orchard Surgery N85047</td>
<td>Bromborough Village Road, Bromborough, Wirral CH62 7EU</td>
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<tr>
<td>The Village Medical Centre N85620</td>
<td>27 Grove Road, Wallasey CH45 3HE</td>
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<td>Townfield Close, Prenton, Wirral CH43 9JW</td>
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<td>Upton Group Practice N85013</td>
<td>32 Ford Road, Upton, Wirral CH49 0TF</td>
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<tr>
<td>Victoria Park Practice N85020</td>
<td>2 Floor, Wing 4 St Catherine’s Health Centre Church Road, Birkenhead, CH42 0LQ</td>
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<td>Villa Medical Centre N85018</td>
<td>Roman Road, Prenton, Wirral CH43 3DB</td>
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<tr>
<td>Vittoria Medical Centre (E) N85038</td>
<td>Vittoria Street, Birkenhead, Wirral CH41 3RH</td>
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<tr>
<td>Vittoria Medical Centre (K) N85634</td>
<td>Vittoria Street, Birkenhead, Wirral CH41 3RH</td>
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<tr>
<td>PRACTICE</td>
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<tr>
<td>West Wirral Group Practice</td>
<td>The Warrens Medical Centre</td>
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<tr>
<td>N85008</td>
<td>Arrowe Park Road</td>
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<td></td>
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<tr>
<td>N85019</td>
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<tr>
<td>Woodchurch Medical Centre</td>
<td>33-35 Poolwood Road, Woodchurch, Wirral</td>
</tr>
<tr>
<td>Y02162</td>
<td>CH49 9BP</td>
</tr>
</tbody>
</table>

Member practices form part of the Membership Council, a forum whereby member practices can come together to discuss and inform key commissioning issues. The principles behind the Members Council meeting are:

- To work effectively with GPs, including sessional and locum GPs, with other practice staff, to feed the practice’s views into commissioning decisions.
- To hold responsive relationships with Board members and member practices
- To give voice to member practices by ensuring members are engaged, informed and empowered to participate.
- To seek advice and views of practice members of Wirral CCG
- To represent their practice’s views and act on behalf of the practice
- Facilitate communication between members and the CCG Governing body and Clinical Senate both ways.
- To help shape the culture of Wirral CCG
- Driving forward improvements in the services for patients, carers, communities

3.1.2. Appendix B of this constitution contains the list of practices, together with the signatures of the practice representatives confirming their agreement to this constitution.

3.2. Eligibility
3.2.1. Providers of primary medical services under any of the following arrangements will be eligible to apply for membership of this Group:

The arrangements are:

a) a general medical services contract to provide primary medical services of a prescribed description

b) arrangements under section 83(2) for the provision of primary medical services of a prescribed description

c) section 92 arrangements for the provision of primary medical services of a prescribed description

4. MISSION, VALUES AND AIMS
The Mission, Vision and aims have been developed by the CCG following consultation from members practices, stakeholders, public and patients.

4.1. **Mission and Vision**

4.1.1. The mission of NHS Wirral Clinical Commissioning Group is:

“Your Partner in a Healthier Future for All”

4.1.2. The vision of NHS Wirral Clinical Commissioning Group is:

“Wirral CCG commits to improve health and reduce disease, by working with patients, public and partners, tackling health inequalities and helping people to take care of themselves.”

4.1.3. The Group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2. **Values**

4.2.1. Good corporate governance arrangements are critical to achieving the Group’s objectives. The values that lie at the heart of the Group’s work are:

a) Caring, fair and responsible
b) Safe and trusted
c) Person-centred

4.3. **Aims**

The aims of the Group are to:

- work with the public and patients to promote self-care by involving and including them in all decisions made about them
- reduce waste, inefficiencies and duplication within the patient journey and between partners
- work in collaboration with our patients, partners, and all stakeholders to deliver needs based healthcare of the highest quality to our diverse population
4.4. Principles of Good Governance

4.4.1. In accordance with section 14L(2)(b) of the 2006 Act, the Group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

b) The Good Governance Standard for Public Services;\(^\text{11}\)

c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the ‘Nolan Principles’\(^\text{12}\)

d) the seven key principles of the NHS Constitution;\(^\text{13}\)

e) the Equality Act 2010\(^\text{14}\)

f) Standards for Members of NHS Bodies and Governing Bodies in England\(^\text{15}\)

4.5. Accountability

4.5.1. The Group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

a) engaging with stakeholders to develop its constitution, which will then be published on its website;

b) appointing independent lay members and non GP clinicians to its Governing Body;

c) holding meetings of its Governing Body in public (except where the Group considers that it would not be in the public interest in relation to all or part of a meeting);

d) publishing annually a commissioning plan;

e) complying with local authority health overview and scrutiny requirements;

f) meeting annually in public to present and subsequently publish its annual report;

g) producing annual accounts in respect of each financial year which must be externally audited;

h) having a published and clear complaints process;

i) complying with the Freedom of Information Act 2000;

\(^{10}\) Inserted by section 25 of the 2012 Act

\(^{11}\) The Good Governance Standard for Public Services, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

\(^{12}\) See Appendix F

\(^{13}\) See Appendix G


\(^{15}\) Standards for Members of NHS Bodies and Governing Bodies in England, Council for Healthcare Regulatory Excellence 2012
j) providing information to NHS England as required

4.5.2. In addition to these statutory requirements, the Group will demonstrate its accountability by:

a) publishing its principal commissioning and operational policies;

b) developing a communications and engagement strategy setting out how it will identify and reach its stakeholders;

c) complying fully with the statutory requirements for internal and external audit, and with the recommendations of any audits undertaken and where appropriate to do so, publish its remuneration details as part of its annual report;

d) having a published and clear process for management of Serious Incidents;

4.5.3. The Governing Body of the Group will throughout each year have an ongoing role in reviewing the Group’s governance arrangements to ensure that the Group continues to reflect the principles of good governance.

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1. The functions that the Group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health’s Functions of clinical commissioning Groups: a working document. They relate to:

a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   i) all people registered with member GP practices, and
   ii) people who are usually resident within the area and are not registered with a member of any clinical commissioning Group;

b) commissioning emergency care for anyone present in the Group’s area;

c) paying its employees’ remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the Group’s employees;

d) determining the remuneration and travelling or other allowances of members of its Governing Body.
5.1.2. In discharging its functions the Group will:

   a) act\(^{16}\), when exercising its functions to commission health services, with the discharge by the Secretary of State and NHS England of their duty to **promote a comprehensive health service**\(^{17}\) and with the objectives and requirements placed on NHS England through the mandate\(^{18}\) published by the Secretary of State before the start of each financial year by:

   i) delegating responsibility for the discharge the CCG’s functions to the Governing Body

   ii) making provision within commissioning plans to prevent ill health and fund comprehensive healthcare for those patients for the Group is responsible

   iii) having robust processes in place to enable the CCG Governing Body to monitor progress against agreed plans

   b) **meet the public sector equality duty**\(^{19}\) by:

   i) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

   ii) delegating responsibility for the oversight of equality work to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

   iii) publishing an annual report detailing performance to demonstrate compliance against the requirements of the Equality Act 2010

   iv) preparing and publishing specific and measurable equality objectives, which will be monitored by the Governing Body, and will be revised at least every four years

   v) holding providers to account through CCG monitoring mechanisms against their duty to meet the requirements of the Equality Act 2010

   vi) adoption of the Equality Delivery System toolkit to support:

   - eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the 2010 Act

   - advancing equality of opportunity between people who share a protected characteristic (as identified in the 2010 Act) and those who do not

   - fostering good relations between people who share a protected characteristic and those who do not

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\(^{16}\) See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

\(^{17}\) See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

\(^{18}\) See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

\(^{19}\) See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act
c) work in partnership with its local authority to develop **joint strategic needs assessments**\(^{20}\) and **joint health and wellbeing strategies**\(^{21}\) by:

i) nominating the Chair of the Governing Body and Accountable Officer as members of the local Health and Wellbeing Board, on behalf of the CCG

ii) promoting the integration of health services with health-related and social care services through:

- ensuring that responsibilities are appropriately discharged through the Health and Wellbeing Board, as specified within its terms of reference
- establish lines of reporting between the Governing Body of the CCG and the Health and Wellbeing Board
- overseeing the development of mechanisms to accurately profile and assess health need
- effective partnership working, collaborative contracting and support for providers across the health economy

5.2. **General Duties** - in discharging its functions the Group will:

5.2.1. Make arrangements to **secure public involvement** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements\(^{22}\) by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of public involvement work to a CCG Governing Body member and a requirement for this member to report on the delivery of this duty

c) setting out our communications and engagement plans through a strategy, to be aligned to its commissioning intentions, to be updated on an annual basis

d) making provision within the Membership of the Governing Body for a lay representative, the full role of which will be outlined within the Governing Body terms of reference, but which will have specific responsibility for ensuring that the voice of the patient is represented at the highest level of decision-making

e) holding meetings of its Governing Body in public

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\(^{20}\) See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

\(^{21}\) See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

\(^{22}\) See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act
f) working in partnership with patients and the local community to secure the best care for them

g) adapting engagement activities to meet the specific needs of the different patient groups and communities

h) publishing information about health services on the Group’s website and through other media

i) encouraging feedback and putting in place a clear mechanism for providing and acting on feedback in relation to commissioning decisions taken by the Governing Body

5.2.2. Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of this duty to a CCG Governing Body member and a requirement for this member to report on the delivery of this duty

c) Ensuring the CCG policies, strategies and plans recognise and reflect this duty

5.2.3. Act effectively, efficiently and economically by:

a) empowering the Chief Financial Officer with responsibility for ensuring that the Group meets its statutory financial duties in full

b) developing a programme of internal and external audit, overseen by the Chief Financial Officer and monitored by the Audit Committee

c) monitoring the achievement of overall CCG financial balance through the Quality, Performance and Finance Committee

d) holding providers to account on the clinical effectiveness of services delivered, through the Quality, Performance and Finance Committee

e) publishing an annual commissioning plan that clearly outlines how the CCG will achieve the required minimum efficiency savings,

f) identifying clear lines of delegated responsibility for achievement of Quality, Innovation, Productivity and Prevention (QIPP), through the CCG governance structure

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23 See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

24 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.4. Act with a view to securing continuous improvement to the quality of services\(^{25}\) by:

a) delegating responsibility for the oversight of this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) discharging responsibility through the Clinical Senate to nominated clinical leads to ensure the continuous improvement of quality of services in their identified clinical lead area

c) Ensuring the CCG commissioning policies, strategies and plans recognise and reflect this duty

d) holding providers to account on delivery of agreed CQUIN schemes through contract management monitored by the Quality, Performance and Finance Committee

e) Publishing an Assurance Framework which will be the primary mechanism through which the CCG, its officers and committees will identify, mitigate and manage risk in relation to commissioned providers

5.2.5. Assist and support NHS England in relation to the Board’s duty to improve the quality of primary medical services\(^ {26}\) by:

a) delegating the responsibility for a programme of general practice peer review and support to the Governing Body, to be reported and monitored through the Quality, Performance and Finance Committee

b) delegating the responsibility for undertaking an annual schedule of practice visits to the Director of Commissioning, which will facilitate discussion on and review of a range of primary care and commissioning issues, and provide a mechanism for highlighting and reporting any areas where further support may be appropriate

c) developing and maintaining close links with primary care stakeholder Groups, including the Local Medical Committee and local Practice Nurse Association

d) providing clear guidance to patients on the mechanism for providing feedback and complaints in relation to primary medical services

e) working closely with the local office of the National Commissioning Board, and agreeing a mechanism for reporting issues relating to any medical performer to the Quality, Performance and Finance Committee

Assist and support NHS England in relation to the NHS England’s duty to improve the quality of specialist services by:

a) Working collaboratively in the undertaking of any local consultation and engagement events with neighbouring CCGs and the NHS England.

b) Undertaking patient experience surveys as required in supporting the NHS England

\(^{25}\) See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{26}\) See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
5.2.6. Have regard to the need to **reduce inequalities** by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of this duty to a CCG Governing Body member and a requirement for this member to report on the delivery of this duty

c) developing commissioning intentions that are aligned to the needs of the population, as identified by the Joint Strategic Needs Assessment and Health and Wellbeing plan

d) jointly developing a strategy with the Local Authority with clear targets and outcomes in relation to a reduction in health inequalities, the delivery and impact of which will be monitored through the Health and Wellbeing Board

e) holding commissioned providers to account, through their contracts, against their plan to improve access for all sections of the population, through identifying and eliminating barriers to access, and monitoring compliance with these contractual requirements through the Quality, Performance and Finance Committee and identified contract monitoring mechanisms

5.2.7. **Promote the involvement of patients, their carers and representatives in decisions about their healthcare** by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of involvement work to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

c) delegating responsibility for promoting the involvement of patients, their carers and representatives in decisions about their healthcare to the Governing Body through the development of patient councils/forums and other patient engagement processes.

d) Involving patients, their carers and representatives in service redesign work.

e) developing a strategy to ensure full compliance with the requirements in relation to patients and carers highlighted within the NHS Operating Framework, to be monitored within the commissioning plan of the Governing Body and of the commissioning divisions

f) holding commissioned providers to account, through their contracts, on their plans to involve patients, their carers and representatives in decisions about their healthcare, and to develop mechanisms for evaluating the extent to which these Groups consider that they have been involved in decisions about their healthcare

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27 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act
28 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
g) monitoring providers’ compliance with these contractual requirements through the Quality, Performance and Finance Committee, and through routine contract monitoring mechanisms

5.2.8. Act with a view to enabling patients to make choices\(^\text{29}\) by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of involvement work to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

c) ensuring that the commissioning strategies of the CCG support patient choice

d) the adoption of the full range of contract procurement options to facilitate patient choice for appropriate services unless it considers that it is inappropriate to do so

e) publishing sufficient information to ensure that patients are aware of the full range of options available in relation to health and social care providers, and that any choice made is an informed choice

f) providing sufficient information to Member Practices to enable clinicians to support patients in decision-making

g) monitoring of the delivery of this duty will be carried out by CCG staff and reported on through the Quality, Performance and Finance Committee

5.2.9. Obtain appropriate advice\(^\text{30}\) from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility to its to Governing Body and all formal committees ensuring that a range of professionals are involved in all levels of decision-making, through the Terms of Reference of the CCG Governing Body

c) securing through the Service Level Agreement (SLA) expertise and advice

d) using the Clinical Senate structure as the framework for facilitating clinical debate and decision-making

e) monitoring of the delivery of this duty will be carried out by CCG staff reporting through the committee structures

5.2.10. Promote innovation\(^\text{31}\) by:

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\(^{29}\) See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{30}\) See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{31}\) See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of promoting innovation to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

c) ensuring that the commissioning strategies of the CCG demonstrate innovative practice wherever appropriate, making use of recognised published best practice and case studies

d) promotion and disseminating good practice e.g. membership of organisations which support the dissemination of good practice

e) monitoring of the delivery of this duty will be carried out by the CCG staff reporting through the committee structures

5.2.11. **Promote research and the use of research**32 by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of promoting research to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

c) Membership of the Local Research Network Board

d) To report on progress through the Quality, Performance and Finance Committee to the Governing Body

5.2.12. Have regard to the need to **promote education and training**33 for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty34 by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of promoting education and training within Member Practices to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

c) working collaboratively with the Local Authority and the NHS England Local Area Team to secure appropriate training for member practices

d) setting out a plan for ensuring access to, and monitoring the uptake of, education and training, for staff employed by or working on behalf of the CCG through the Organisational Development plan

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32 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
33 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
34 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
e) delegating responsibility to the Director of Commissioning to support the education and training of staff working within the member practices for delivery of healthcare services that will directly support the commissioning intentions of the CCG as detailed in the standing orders/scheme of reservation and delegation

f) utilising the Clinical Senate structure to identify and address any education and training needs to support the delivery of the CCG commissioning intentions

g) utilising contracts with commissioned providers and contract monitoring process to provide assurance that staff delivering commissioned services have received the necessary education and training to carry out their role

5.2.13. Act with a view to promoting integration of both health services with other health services and health services with health-related and social care services where the Group considers that this would improve the quality of services or reduce inequalities by:

a) delegating accountability for this duty to the Accountable Officer and a requirement for them to assure the delivery of this duty

b) delegating responsibility for the oversight of promoting integration to a CCG Governing Body member and a requirement for this member to report on the delivery of the duty to the Governing Body

c) involving health and social care providers in the development of the commissioning plans of the CCG

d) ensuring that commissioning intentions are based upon full and robust review of all available and relevant intelligence and information regarding health and social care provision including the JSNA and Health and Wellbeing plan

e) aligning the commissioning plans and intentions of the CCG and the Local Authority, to be overseen and monitored by the respective Boards and the Health and Wellbeing Board

5.3. General Financial Duties – the Group will perform its functions so as to:

5.3.1. Ensure its expenditure does not exceed the aggregate of its allotments for the financial year by

a) the Chief Financial Officer having delegated responsibility for ensuring that the CCG delivers its duties for the financial year, using the committee structure to flag financial risks of potential non-performance of this as appropriate

b) a Scheme of Delegation and Standing Financial Instructions

35 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
36 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
c) monitoring its planned expenditure through the financial year and via receipt of regular financial performance reports by the Chief Financial Officer to the Quality, Performance and Finance Committee and the Governing Body. Financial performance reports will be received by its quality performance and finance committee monitoring progress against its total allotment for the year, with overall budgetary responsibility being delegated to the Governing Body to monitor and pursue remedial actions in accordance with requirements

5.3.2. **Ensure its use of resources** (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year\(^{37}\) by

a) the Chief Financial Officer having delegated responsibility for this duty

b) a Scheme of Delegation and Standing Financial Instructions

c) monitoring its planned expenditure of applicable capital and revenue resource through its financial reporting arrangements as outlined in 5.3.1 to ensure expenditure does not exceed the resource available

5.3.3. **Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the Group does not exceed an amount specified by NHS England**\(^{38}\) by

a) the Chief Financial Officer having delegated responsibility for this duty

b) reflecting such directions within a Scheme of Delegation and Standing Financial Instructions

c) monitoring its planned expenditure in respect of specified types of resource use through its financial reporting arrangements as outlined in 5.3.1 to ensure expenditure does not exceed the resource available

5.3.4. **Publish an explanation of how the Group spent any payment in respect of quality** made to it by NHS England\(^{39}\) by

a) the Chief Financial Officer having delegated responsibility for this duty

b) including an appropriate section within the CCG’s annual report

5.4. **Other Relevant Regulations, Directions and Documents**

5.4.1. The Group will

a) comply with all relevant regulations;

b) comply with directions issued by the Secretary of State for Health or NHS England; and

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\(^{37}\) See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{38}\) See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{39}\) See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act
5.4.2. The Group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its scheme of reservation and delegation and other relevant Group policies and procedures.

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

The Clinical Commissioning Group is accountable for exercising its statutory functions through its Governing Body. Subject to any limitations by law, it may grant authority to act on its behalf to:

a) Employees or Officers of the Group
b) Audit Committee
c) Remuneration Committee
d) Quality, Performance and Finance Committee
e) Clinical Senate
f) Approvals Committee

The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the Group as expressed through:

a) the Group’s scheme of reservation and delegation; and
b) for committees, their terms of reference

6.2. Scheme of Reservation and Delegation

6.2.1. The Group’s scheme of reservation and delegation sets out:

a) those decisions that are reserved for the membership as a whole;
b) those decisions that are the responsibilities of its Governing Body, its sub committees, individual members and employees
c) the potential impact of the decisions made by the group/committee.

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40 See Appendix D
6.3 **General**

6.3.1 In discharging functions of the Group that have been delegated by its Governing Body to its committees, (Audit, Remuneration, Quality, Performance and Finance, Clinical Senate, and Approvals), individuals must:

a) comply with the Group’s principles of good governance\(^{41}\)

b) operate in accordance with the Group’s scheme of reservation and delegation\(^{42}\)

c) comply with the Group’s standing orders\(^{43}\)

d) comply with the Group’s arrangements for discharging its statutory duties\(^{44}\)

e) where appropriate, ensure that member practices have had the opportunity to contribute to the Group’s decision making process.

6.3.2 When discharging their delegated functions, the Audit, Remuneration, Quality, Performance and Finance, Clinical Senate, and Approvals Committees must also operate in accordance with their approved terms of reference.

6.3.3 Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements must:

a) identify the roles and responsibilities of those who are working together

b) identify any pooled budgets and how these will be managed and reported in annual accounts

c) in the case of collaborating CCGs, specify under which scheme of reservation and delegation and supporting policies the collaborative working arrangements will operate

d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties

e) identify how disputes will be resolved and the steps required to terminate the working arrangements

f) specify how decisions are communicated to the collaborative partners

6.4 **Committees of the Group**

6.4.1 The following committees have been established by the Group:

a) Audit Committee

b) Remuneration Committee

c) Quality Performance and Finance Committee

d) Clinical Senate

e) Approvals Committee

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\(^{41}\) See section 4.4 on Principles of Good Governance above

\(^{42}\) See appendix D

\(^{43}\) See appendix C

\(^{44}\) See chapter 5 above
6.4.2 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the Governing Body.

6.5 Joint Arrangements
6.5.1 At present, the Governing Body does not have any joint (or collaborative) arrangements with other clinical commissioning groups. The CCG has a Section 256 agreement in place with Wirral Borough Council and may enter into further joint arrangements to enable co-commissioning with NHS England.

6.6 The Governing Body
6.6.1 **Functions** - the Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution. The Governing Body has responsibility for:

a) ensuring that the Group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the Groups *principles of good governance* (its main function)

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act

c) approving any functions of the Group that are specified in regulations

d) leading the setting of the vision and strategy

e) promoting the involvement of all Members in the work of the CCG in securing improvements in commissioning of care and services.

f) promoting partnerships within the local health system with patients, the public and other stakeholders and promote the involvement of patients and their carers and representatives (if any) in decisions about the provision of health services to patients;

g) engaging with the local Health and Wellbeing Board and nominating the Accountable Officer and Chair of the Governing Body to act as its representatives in relation to each such Health and Wellbeing Board;

h) ensuring that the register of interests is reviewed, regulated and updated as necessary and managing any conflicts of interest that may arise;

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45 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
46 See section 4.4 on Principles of Good Governance above
47 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
i) securing effective clinical engagement in the decisions of the CCG through effective partnership work with clinicians within the health economy;

j) preparing the Annual Plan to present to the Members and partners at the AGM;

k) keeping accurate accounts and records and preparing the Accounts to present to the Members acting through their Practice Representatives at the AGM;

l) establish any links and working arrangements with other clinical commissioning Groups or other strategic partners as may from time to time be deemed appropriate

m) receiving assurance from the Audit Committee that corporate, finance, information and quality governance systems are all working effectively;

n) assess the impact of, and approve the plans for, demand, financial and investment needs of the CCG;

o) participating in and monitoring clinical networks

6.6.2 Composition of the Governing Body - the Governing Body shall have 17 voting members to include the following:

a) Five GP Executive Leads:
   - One GP Executive Lead – Long Term Conditions
   - One GP Executive Lead – Unplanned Care
   - One GP Executive Lead – Primary Care
   - One GP Executive Lead – Planned Care
   - One Medical Director (who also acts as the Assistant Clinical Chair of the Governing Body)

b) Three Lay Members:
   - One Lay Member – Audit and Governance, to lead on audit, governance, remuneration and conflict of interest matters (who also acts as the Deputy Chair of the Governing Body)
   - One Lay Member – Patient Champion, to lead on patient and public participation matters
   - One Lay Member – Quality and Outcomes, to lead on quality and outcomes

c) One Director of Quality and Patient Safety

d) One Membership Council Representative

e) One Registered Nurse

f) One Director of Corporate Affairs

g) One Director of Commissioning

h) One Secondary Care Doctor
i) The Accountable Officer
j) One Chair of the Governing Body
k) One Chief Financial Officer

The Governing Body may invite such other person(s) to attend all or any of its
meetings, or part(s) of a meeting, in order to assist it in its decision-making and in
its discharge of its functions as it sees fit. Any such person may speak and
participate in debate, but may not vote.

The Governing Body will invite the following individuals to attend any or all of its
meetings and participate in the way described in paragraph above:

- Public Health Representative
- Local Authority Representative
- Healthwatch representative
- Local Medical Committee Representative

6.7 Committees of the Governing Body

The Governing Body appointed the following committees and sub-committees:

6.7.1 Audit Committee – the Audit committee, which is accountable to the Group’s
Governing Body, provides the Governing Body with an independent and
objective view of the Group’s financial systems, financial information and
compliance with laws, regulations and directions governing the Group in so far
as they relate to finance. The Governing Body has approved and keeps under
review the terms of reference for the audit committee, which includes information
on the membership of the audit committee.\(^{48}\)

In addition the Governing Body has conferred or delegated the following
functions, connected with the Governing Body’s main function\(^{49}\), to its audit
committee:

a) Integrated governance, risk management and internal control; in particular
the committee will review the adequacy and effectiveness of:

i. all risk and control related disclosure statements together with any
appropriate independent assurances, prior to endorsement by the
CCG

ii. the underlying assurance processes that indicate the degree of
achievement of the clinical commissioning Group objectives, the
effectiveness of the management of principle risks and the
appropriateness of disclosure statements

\(^{48}\) See appendix H for the terms of reference of the Audit Committee
\(^{49}\) See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act
iii. the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification

iv. the policies and procedures for all work related fraud and corruption as set out in Secretary of State directions and as required by the NHS Counter Fraud and Security management service

b) Internal audit, the committee will ensure that there is an effective internal audit function that meets mandatory NHS internal audit standards and provides assurance to the audit committee. This will be achieved by:

i. consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal

ii. review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework

iii. considering the major findings of the internal audit work, and ensuring coordination between the internal and external auditors to optimise resources

iv. ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning Group

v. an annual review of the effectiveness of internal audit

c) External Audit; the committee will review the works and findings of the external auditors and consider the implications of the work. This will be achieved by:

i. consideration of the performance of the external auditors

ii. discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring coordination, as appropriate with other external auditors within the local health economy

iii. discussion with the external auditors of their local evaluation of audit risks and assessment of the clinical commissioning Group and associated impact on the audit fee

iv. review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the audit plan, together with the appropriateness of management responses

d) Other assurance functions. The audit committee shall review the findings of other significant assurance functions, both the internal and external and
consider the implications for the governance of the clinical commissioning Group.

e) Counter fraud - the committee will ensure that the clinical commissioning Group has adequate arrangements in place for countering fraud.

f) Information Governance - the committee will ensure that the clinical commissioning Group has adequate arrangements in place for Information Governance facilitated through use of the Information Governance Toolkit.

g) Management - the committee will review reports and positive assurances from directors and managers on the overall arrangements for governance and risk.

h) Financial reporting - the committee will monitor the integrity of the financial statements of the clinical commissioning Group.

6.7.2 Composition of the Audit Committee

Voting Members

Lay Member – Audit & Governance (Chair)
Lay Member – Patient Champion

Three Audit Lay members, appointed to via a recruitment process to provide additional independent scrutiny

‘In Attendance’ Non-Voting Members

Chief Financial Officer
Director of Corporate Affairs
Accountable Officer (at least annually)
Chair of the Governing Body (at least annually)
Mersey Internal Audit Agency Manager/Client Lead
External Audit Manager
Local Counter Fraud Specialist
Minute Taker

6.7.3 Remuneration Committee

The Remuneration Committee, which is accountable to the Group’s Governing Body makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The Governing Body has approved and keeps under review the terms of reference for the remuneration committee, which includes information on the membership of the Remuneration Committee.\(^{50}\)

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\(^{50}\) See appendix H for the terms of reference of the remuneration committee.
In addition the Governing Body has conferred or delegated the following functions, connected with the Governing Body’s main function, to its Remuneration Committee:

i) determining the remuneration and conditions of service of the senior team not covered by Agenda for Change on the recommendations of the Accountable Officer

ii) determining the remuneration and the conditions of service of the Accountable Officer

iii) reviewing the performance of the Accountable Officer and other senior team members and determining annual salary awards

iv) approving the severance payments of the Accountable Officer and usually other senior staff

a) **Composition of the Remuneration Committee**

b) Three Lay Members – voting

c) Secondary Care Doctor-voting

d) Chair of the Governing Body- voting

e) A Human Resources representative from the North West Commissioning Support Unit will be invited to attend the meetings – non-voting.

f) The Accountable Officer - non-voting.

**6.7.4 Quality, Performance and Finance Committee**

The quality, performance and finance committee is accountable to the Group’s Governing Body. The functions of this committee are:

a) to seek assurance that the commissioning strategy for the Clinical Commissioning Group reflects all elements of quality

b) provide assurance that the services that are commissioned are being delivered in a high quality and safe manner across the Clinical Commissioning Group

c) be assured that effective management of risk is in place to manage and address clinical governance issues

d) have oversight of compliance issues concerning serious incidents

e) seek assurance on performance of NHS organisations in terms of waiting times targets, CQC and monitor

f) receive and scrutinise independent investigations relating to patient safety issues

The Governing Body has approved and keeps under review the terms of reference for the quality, performance and finance committee which includes information on the membership of the committee.\(^{51}\)

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\(^{51}\) See appendix H for the terms of reference of the Quality, Performance & Finance Committee.
6.7.5 Composition of the Quality, Performance and Finance Committee

a) Chair of the Governing Body
b) Accountable Officer
c) Chief Financial Officer
d) Director of Quality and Patient Safety
e) Director of Commissioning
f) Director of Corporate Affairs
g) Lay Member – Patient Champion
h) Lay Member – Audit & Governance
i) Lay Member – Quality and Outcomes
j) Two GP Executive Leads from Governing Body

6.7.6 Clinical Senate

The Clinical Senate is accountable to the Governing Body. The functions of the Clinical Senate are to:

Inform Commissioning Reform in the areas of:

- Major clinical strategic areas including clinical service planning and reform, models of care and service delivery
- Strategies to improve patient care by improving the integration of services to patients across all settings of care
- Identifying relevant innovations, emergent best practice and research findings in healthcare to inform future strategies
- Strategies to support the transformation of health and social care services to reduce the growth in hospital demand

Influence Clinical Excellence in the areas of:

- Strategies to implement clinical guidelines and standards
- Strategies to improve the safety quality, efficiency and sustainability of clinical services and prevention strategies
- Strategies to improve the professional links between partners organisations and professional groups

Recommend

- Discuss and make recommendations on key clinical issues as determined by the Governing Body

Engage
• Provide a forum for multidisciplinary discussion of redesign and clinical developments
• Improve engagement of clinicians in influencing the future commissioning intentions and delivery
• Provide a further opportunity for the provision of assurance that new models of care / pathways will have a positive impact on patient safety and experience

6.7.7 Composition of the Clinical Senate

• Medical Director
• Director of Quality and Patient Safety
• Four GP Executive Leads
• Other GPs co-opted with particular interest and expertise as appropriate to the work plan
• Secondary Care Doctor
• Nursing Representative
• Two Therapist representatives (must be different professional groups)
• Local Medical Committee representative
• Pharmacist/medicines management representative
• 3 Provider representatives (Mental Health, Community, Acute)
• Public Health Representative

In addition to this Senate, the CCG will establish two further subgroups that will further strengthen engagement specifically with member practices.

The first of these is the Membership Council, a forum whereby member practices can come together to discuss and inform key commissioning issues. This will be led by the GP Executive – Primary Care. This meeting will be held at least 4 times a year and the principles behind the Members Council meeting are:

• To work effectively with GPs, including sessional and locum GPs, with other practice staff, to feed the practice’s views into commissioning decisions.
• To hold responsive relationships with Board members and member practices
• To give voice to member practices by ensuring members are engaged, informed and empowered to participate.
• To seek advice and views of practice members of the CCG
• To represent their practice’s views and act on behalf of the practice
• Facilitate communication between members and the CCG Governing body and Clinical Board both ways.
• To help shape the culture of the CCG
• Driving forward improvements in the services for patients, carers, communities
The second of these is the GP Provider Forum. This forum will be where GP practices can meet to discuss issues regarding GP practices in their roles as providers. This will be led by the GP Executive – Primary Care and would focus on issues such as implementation of enhanced services and other local schemes, Primary Care workforce issues, and other topical issues.

With the development of co-commissioning this forum is seen as a critical part of the new architecture.

**Approvals Committee**

In order to facilitate the achievement of good governance, the Approvals Committee is established as a Sub-committee of the Governing Body and is authorised to provide independent scrutiny on commissioning decisions, where there are potential conflict of interest implications.

a) It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

b) It is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

c) The purpose/role of the Committee will be to scrutinize commissioning decisions where a conflict of interest prevents the Governing Body from making these decisions

d) The Committee will use core national criteria when assessing clinical decisions and ensure that commissioning proposals support the strategic intentions of the CCG

### 6.7.8 Composition of Approvals Committee

a) Lay Member – Audit and Governance(Chair) - voting  
b) Lay Member – Patient Champion – voting  
c) Lay Member – Quality and Outcomes - voting  
d) Lay Member (Audit Committee Lay Member) - voting  
e) Lay Member (Audit Committee Lay Member) - voting  
f) Director of Public Health - voting  
g) Secondary Care Doctor – voting  
h) Registered Nurse - voting  
i) Chief Financial Officer  
j) Director of Quality and Patient Safety
7. Roles and Responsibilities

7.1 All Members of the Group’s Governing Body

Guidance on the roles of members of the Group’s Governing Body is set out in a separate document\textsuperscript{53}. In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the Group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

The Chair of the Governing Body

7.2 The chair of the Governing Body is responsible for:

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution

b) building and developing the Group’s Governing Body and its individual members

c) ensuring that the Group has proper constitutional and governance arrangements in place

d) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties

e) supporting the Accountable Officer in discharging the responsibilities of the organisation

f) contributing to building a shared vision of the aims, values and culture of the organisation

g) leading and influencing to achieve clinical and organisational change to enable the Group to deliver its commissioning responsibilities

h) overseeing governance and particularly ensuring that the Governing Body and the wider Group behaves with the utmost transparency and responsiveness at all times

i) ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met

j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England

k) ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority

7.3 The Deputy Chair and Assistant Clinical Chair of the Governing Body

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\textsuperscript{53} Draft clinical commissioning Group Governing Body Members – Roles Attributes and Skills, NHS Commissioning Board Authority, March 2012
7.3.1 The Deputy Chair of the Governing Body will be the Lay Advisor – Audit and Governance. They will chair meetings of the Governing Body on occasions when the Chair of the Governing Body has a conflict of interest and cannot participate in the relevant meeting or part of it.

7.3.2 The Medical Director will be the Assistant Clinical Chair of the Governing Body. They will chair meetings of the Governing Body on occasions when the Chair of the Governing Body is unable to attend the relevant meeting or part of it for reasons other than a conflict of interest.

7.3.3 Where both the Chair and either the Deputy Chair or Clinical Assistant Chair (as applicable) cannot participate in the relevant meeting or part of it, the voting members in attendance at the relevant meeting will select one.

7.4 Role of the Accountable Officer

7.4.1 The Accountable Officer of the Group is a member of the Governing Body. This role of Accountable Officer (to be called Chief Clinical Officer if the role is occupied by a GP) has been summarised in a national document54 as:

a) being responsible for ensuring that the Clinical Commissioning Group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money

b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems

c) working closely with the chair of the Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation’s ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff

d) Safeguarding for Children and Adults – the Accountable Officer will be the executive lead for the safeguarding of adults

e) leading interactions with stakeholders, including NHS England

f) being responsible for all matters relating to information governance and data security.

7.5 Role of the Chief Financial Officer

7.5.1 The Chief Financial Officer is a member of the Governing Body who has a professional qualification in accountancy and the expertise or experience to lead the financial management of the Group. The Chief Financial Officer is responsible

54 See the latest version of NHS England Authority’s Clinical commissioning Group Governing Body members: Role outlines, attributes and skills

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for providing financial advice to the Group and for supervising financial control and accounting systems. This role of Chief Financial Officer has been summarised in a national document\(^55\) as:

a) being the Governing Body’s professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged

b) making appropriate arrangements to support, monitor on the Group’s finances

c) overseeing robust audit and governance arrangements leading to propriety in the use of the Group’s resources

d) being able to advise the Governing Body on the effective, efficient and economic use of the Group’s allocation to remain within that allocation and deliver required financial targets and duties

e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England

7.5.2 Additionally the Chief Financial Officer will be the responsible officer for serious incident reporting as Senior Information Reporting Officer (SIRO)

7.6 Medical Director

This role will provide leadership of the Clinical Senate and engagement with the clinical community and Medical Directors in provider organisations. The role will also act in the role as Chair when the Chair is unable to attend for reasons other than a conflict of interest. The post will work closely with the Director of Quality and Patient Safety in ensuring quality in all commissioned services, involvement in serious incident reviews and in the development of the Commissioning for Quality and Innovation payment framework (CQIUN). The post will:

a) provide clinical expertise for the development of commissioning plans to the Governing Body and its subcommittees

b) develop and support clinical ownership and engagement across all sectors of health and social care

c) ensure that health promotion, health inequalities and disease prevention are an integral part of plans

d) support the achievement of key targets and standards

e) champion the involvement of patients in service planning, redesign and monitoring

f) Line manage and support the GP Executive Leads

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\(^{55}\) See the latest version of NHS England Authority’s *Clinical commissioning Group Governing Body members: Role outlines, attributes and skills*
The Medical Director also acts as the Assistant Clinical Chair, who chairs meetings of the Governing Body in accordance with paragraph 7.3.1 of this constitution on occasions when the Chair is unable to attend the relevant meeting or part of it for reasons other than a conflict of interest.

7.7 **GP Executive Lead – Planned Care**

This role will provide clinical leadership in Planned Care and oversee the Out of Hospital and Transformation agenda. The post will:

a) provide clinical expertise for the development of commissioning plans to the Governing Body and its subcommittees

b) develop and support clinical ownership and engagement across all sectors of health and social care

c) ensure that health promotion, health inequalities and disease prevention are an integral part of plans

d) support the achievement of key targets and standards

e) champion the involvement of patients in service planning, redesign and monitoring

f) support and develop the engagement of all GP practices in commissioning arrangements

7.8 **GP Executive Lead – Unplanned Care**

This role will provide clinical leadership in Unplanned Care and oversee the Urgent Care Working Group and the System Resilience Group. The post will:

a) provide clinical expertise for the development of commissioning plans to the Governing Body and its subcommittees

b) develop and support clinical ownership and engagement across all sectors of health and social care

c) ensure that health promotion, health inequalities and disease prevention are an integral part of plans

d) support the achievement of key targets and standards

e) champion the involvement of patients in service planning, redesign and monitoring

f) support and develop the engagement of all GP practices in commissioning arrangements

7.9 **GP Executive Lead – Long Term Conditions**

This role will provide clinical leadership in Long Term Conditions and oversee the Integration and aspects of the co-commissioning agenda. The post will:

a) provide clinical expertise for the development of commissioning plans to the Governing Body and its subcommittees
b) develop and support clinical ownership and engagement across all sectors of health and social care

c) ensure that health promotion, health inequalities and disease prevention are an integral part of plans

d) support the achievement of key targets and standards

e) champion the involvement of patients in service planning, redesign and monitoring

f) support and develop the engagement of all GP practices in commissioning arrangements

7.10 GP Executive Lead – Primary Care

This role will provide clinical leadership in Primary Care and support and liaise with the Membership Council and the GP Provider Forum. The post will:

a) provide clinical expertise for the development of commissioning plans to the Governing Body and its subcommittees

b) develop and support clinical ownership and engagement across all sectors of health and social care

c) ensure that health promotion, health inequalities and disease prevention are an integral part of plans

d) support the achievement of key targets and standards

e) champion the involvement of patients in service planning, redesign and monitoring

f) support and develop the engagement of all GP practices in commissioning arrangements

7.11 Membership Council Representative

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, this clinical member will bring a broader view on health and care issues to underpin the work of the CCG. In particular, they will bring to the Governing Body an understanding of patient care from the view of member practices. They will also:

a) be a GP who has been elected by the Membership Council to represent members;

b) be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

c) be highly regarded as a clinical leader with a track record of collaborative working;

d) be able to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value;

e) be able to contribute a generic view from the perspective of member practices whilst putting aside specific issues relating to their own clinical practice; and
7.12 Secondary Care Doctor

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, this clinical member will bring a broader view, on health and care issues to underpin the work of the CCG. In particular, they will bring to the Governing Body an understanding of patient care in the secondary care setting. They will also:

a) be a doctor who is, or has been, a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting;

b) be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business;

c) be highly regarded as a clinical leader, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working;

d) be able to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value;

e) be able to contribute a generic view from the perspective of a secondary care doctor whilst putting aside specific issues relating to their own clinical practice or their employing organisation’s circumstances; and

f) be able to provide an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service redesign, clinical pathways and system reform.

g) Whilst the individual may well no longer practice medicine, they will need to demonstrate that they still have a relevant understanding of care in the secondary setting. The individual should not be employed by any organisation from which the CCG secures any significant volume of provision.

7.13 Director of Commissioning

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, the Director of Commissioning will lead the commissioning, system transformation and service design of the Wirral health economy to ensure the delivery of high quality care and that the strategic objectives and performance targets of the CCG are met.

This person will have extensive specialist knowledge of contracting models and procurement routes, so as to enable change through appropriate processes that maximise efficiency and choice. The person also ensures plan alignment with local providers and commissioners. This will include ensuring all planning is consistent with Vision 2018, a programme board that oversees the 5 year vision for the whole Wirral economy, both in terms of the commissioning and provider landscape.

The post manages the CCG’s service design and commissioning team and will be responsible for the Programme Management Office that is used to monitor plan Strategic and Operational Plan Delivery. The post contributes to the Governing
Body in the evolution of the CCG’s vision and strategic direction, including the formulation of 5 year health economy strategy, CCG’s 2 yearly planning, policy and the delivery of corporate and statutory performance and outcomes.

This person will work with the Accountable Officer and the Governing Body and develop detailed programme plans, including finance, workforce and risk management to deliver corporate delivery objectives. This will ensure the inclusion of quality metrics that are measurable and informed by all the key stakeholders including patients and carers are also worked through.

7.14 Director of Corporate Affairs

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, the Director of Corporate Affairs will be responsible for a range of corporate functions and responsibilities. These include corporate governance, risk management, legal advice, communications, complaints and claims management, emergency preparedness resilience and response, the Programme Management Office, workforce, human resources and organisational development. This includes overseeing the management of a range of statutory duties including Freedom of Information, Data Protection and Emergency Planning & Business Continuity.

This person is the principal advisor to the Chair and Accountable Officer on all issues relating to corporate governance, ensuring that the organisation’s governance is undertaken to the highest standards of probity and according to statutory and legislative requirements so that the CCG is able to discharge its duties efficiently, effectively and economically. The post holder is responsible for ensuring that the CCG operates in accordance with statutory and regulatory provisions and the Terms of Authorisation, and that there is appropriate stewardship and corporate governance of the business of the CCG. The post holder is responsible for facilitating the smooth operation of the CCG's formal decision and reporting machinery, ensuring that returns and formal CCG papers are completed and maintained appropriately, and advising the Governing Body members on their responsibilities.

7.15 Director of Quality and Patient Safety

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, the Director of Quality and Patient Safety will be a registered nurse with a high level of professional expertise and knowledge. The post holder will be responsible for the formulation of strategy and policy in relation to quality, oversight of the delivery of quality outcomes and having an external focus to facilitate greater working across the healthcare economy and the partners therein.

The role will have responsibility for the production of a strategic approach to quality improvement, clinical policy, continuous improvement processes, patient experience/engagement and systems to ensure that both CCGs commission for quality, incentivise providers to continuously improve through regular monitoring
and reviews (including CQUIN), and develop collaborative programmes of work with providers to ensure intelligence led, continuous quality improvement across the healthcare economy.

The post will be required to lead and direct the CCG in the production of its quality strategy and safeguarding strategy and will be accountable for the co-ordination and management of performance monitoring and quality assurance.

As the CCG’s Lead for Safeguarding, the post holder will manage and develop the CCG’s approach to safeguarding.

7.16 Lay Member – Audit and Governance

The role of this lay member will be to bring specific expertise and experience to the work of the Governing Body. This lay member must have qualification, expertise or experience such as to enable them to express informed views about financial management and audit matters. Their focus will be strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation. They will also:

a) oversee key elements of governance including the management of conflicts of interest and systems of risk management. have a lead role in ensuring that the Governing Body and the wider CCG behaves with the utmost probity at all times

b) have a specific role in ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place

c) chair the remuneration and appointments committee which will include responsibility for succession planning for clinical and managerial leadership within the organisation

d) deputise for the chair where there are significant conflicts of interest:

The Lay Member – Audit and Governance also acts as the Deputy Chair, who chairs meetings of the Governing Body in accordance with clause 7.3.2 of the constitution on occasions when the Chair has a conflict of interest and cannot participate in the relevant meeting or part of it.

7.17 Lay Member – Patient Champion

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, as a lay member on the CCG’s Governing Body they will bring specific expertise and experience, as well as their knowledge as a member of the local community, to the work of the Governing Body. They must have knowledge about the area covered by the Group so as to be able to express informed views about the discharge of the Group’s functions. Their focus will be strategic and impartial, providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation.

This person will help to ensure that, in all aspects of the CCG’s business the public voice of the local population is heard and that opportunities are created and
protected for patient and public empowerment in the work of the CCG. In particular they will ensure that:

a) public and patients’ view are heard and their expectations are understood and met as appropriate.

b) the CCG builds and maintains an effective relationship with Local Healthwatch and draws on existing patient and public engagement and involvement expertise.

c) the CCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

It is not intended that this role should have executive oversight of patient and public engagement rather that the individual ensures, through the appropriate governance processes, that this function is being discharged effectively.

7.18 Lay Member – Quality and Outcomes

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, as a lay member on the CCG’s Governing Body they will bring specific expertise and experience, as well as their knowledge as a member of the local community, to the work of the Governing Body. Their focus will be strategic and impartial, providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation.

This person will help to ensure that, in all aspects of the CCG’s business, there is a focus on the best outcomes for patients and the highest quality of care. In particular they will ensure that quality is central to all services commissioned by the CCG and can be demonstrated through robust metrics.

7.19 Registered Nurse

As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, as a registered nurse on the Governing Body, this person will bring a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the CCG especially the contribution of nursing to patient care. They will also:

a) be a registered nurse who has developed a high level of professional expertise and knowledge

b) be competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business

c) be highly regarded as a clinical leader, probably across more than one clinical discipline and/or specialty – demonstrably able to think beyond their own professional viewpoint

d) be able to take a balanced view of the clinical and management agenda and draw on their specialist skills to add value
e) be able to contribute a generic view from the perspective of a registered nurse whilst putting aside specific issues relating to their own clinical practice or employing organisation’s circumstances

f) be able to bring detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform

g) The individual should not be employed by any organisation from which the CCG secures any significant volume of provision. The individual should bring significant additional perspectives beyond primary care and should not be a general practice employee. This is especially in relation to this particular role and does not preclude practice nurses from being members of the Governing Body in other capacities, for instance as the health professionals acting on behalf of member practices.

7.20 Joint Appointments with other Organisations

The Group has no joint appointment[s] with other organisation[s] at present, but may wish to enter into such arrangements in the future.

8 STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1 Standards of Business Conduct

8.1.1 Employees, members, committee and sub-committee members of the Group and members of the Governing Body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the Group and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles). The Nolan Principles are incorporated into this constitution at Appendix F.

8.1.2 They must comply with the Group’s policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the Group’s website at www.wirralccg.nhs.uk and as detailed in the CCG’s Publication Policy.

8.1.3 Individuals contracted to work on behalf of the Group or otherwise providing services or facilities to the Group will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

8.2 Conflicts of Interest

8.2.1 As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the clinical commissioning Group will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the
Group will be taken and seen to be taken without inappropriate influence of external or private interest.

8.2.2 A conflict of interest might include:

   i) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

   ii) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

   iii) a non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary, community and faith sector provider that is bidding for a contract);

   iv) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual’s house);

   v) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories

8.2.3 Where an individual, i.e. an employee, Group member, member of the Governing Body, or a member of a committee or a sub-committee of the Group or its Governing Body has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the Group considering an action or decision in relation to that interest, it must be considered as a potential conflict, and is subject to the provisions of this constitution.

8.2.4 If in doubt, the individual concerned should assume that a potential conflict of interest exists.

### 8.3 Declaring and Registering Interests

8.3.1 The Group will maintain one or more registers of the interests of the following and their close family members:

   i) the members of the Group

   ii) the members of its Governing Body

   iii) the members of its committees or sub-committees and the committees or sub-committees of its Governing Body and

   iv) its employees

8.3.2 The registers will be published on the Group’s website at www.wirralccg.nhs.uk
8.3.3 Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the Group, in writing to the Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.4 Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.3.5 The Governing Body will ensure that the register(s) of interest is reviewed annually, and updated as necessary.

8.4 Managing Conflicts of Interest: general

8.4.1 Individual members of the Group, the Governing Body, committees or sub-committees of its Governing Body and employees will comply with the arrangements determined by the Group for managing conflicts or potential conflicts of interest.

8.4.2 The Governing Body will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the Group’s decision making processes.

8.4.3 Arrangements for the management of conflicts of interest are to be determined by the Governing Body and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

i) when an individual should withdraw from a specified activity, on a temporary or permanent basis

ii) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual

8.4.4 Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the Group’s exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Governing Body.

8.4.5 Where an individual member, employee or person providing services to the Group is aware of an interest which:

i) has not been declared, either in the register or orally, they will declare this at the start of the meeting

ii) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests
8.4.6 The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

8.4.7 Where the chair of any meeting of the Group, including committees, sub-committees, or the Governing Body and the Governing Body’s committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

8.4.8 Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning Group, committees or sub-committees, or the Governing Body, the Governing Body’s committees or sub-committees, will be recorded in the minutes which will be published on the CCG website thus ensuring public accountability for the processes of managing potential conflicts of interest.

8.4.9 Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

8.4.10 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the Group’s standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with approvals committee on the action to be taken. Members of the approvals committee are as detailed in section 6.7.12 of this constitution.

8.4.11 These arrangements must be recorded in the minutes.

8.4.12 In any transaction undertaken in support of the clinical commissioning Group’s exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the Governing Body of the transaction.
8.4.13 The Governing Body will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

8.5 Managing Conflicts of Interest: contractors and people who provide services to the Group

8.5.1 Anyone seeking information in relation to procurement, or participating in procurement, or otherwise engaging with the clinical commissioning Group in relation to the potential provision of services or facilities to the Group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

8.5.2 Anyone contracted to provide services or facilities directly to the clinical commissioning Group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.5.3 Further details about managing conflicts of interest can be found in the CCG’s Conflicts of Interest Policy available on the Group’s website at www.wirralccg.nhs.uk and as detailed in the CCG’s Publication Policy.

8.6 Transparency in Procuring Services

8.6.1 The Group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The Group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

8.6.2 The Group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

   i) all relevant clinicians (not just members of the Group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services

   ii) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way

8.6.3 Copies of this Procurement Strategy will be available on the Group’s website at www.wirralccg.nhs.uk and as detailed in the CCG’s Publication Policy.
9 THE GROUP AS AN EMPLOYER

9.1 The Group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the Group.

9.2 The Group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.

9.3 The Group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the Group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.

9.4 The Group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The Group will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters.

9.5 The Group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.

9.6 The Group will ensure that employees' behaviour reflects the values, aims and principles set out above.

9.7 The Group will ensure that it complies with all aspects of employment law.

9.8 The Group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.

9.9 The Group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have means through which their concerns can be voiced. The group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its Governing Body, any member of any of its committees or sub-committees or the committees or sub-committees of its Governing Body, or any employee of the group or of any of its members nor will it affect the rights of any worker (as defined in that Act) under that Act.

9.10 Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the Group’s website at http://www.wirralccg.nhs.uk/ and as detailed in the CCG’s Publication Policy.

9.11 The Group will have an organisational development policy to ensure its staff have the relevant knowledge skills and experience to be an effective commissioning
10 TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1 General

a) The Group will publish annually a commissioning plan and an annual report, presenting the Group’s annual report to a public meeting.

b) Key communications issued by the Group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the Group’s website at http://www.wirralccg.nhs.uk/ and as detailed in the CCG’s Publication Policy.

c) The Group may use other means of communication, including circulating information by post, or making information available in other venues or services accessible to the public.

10.2 Standing Orders

a) This constitution is also informed by a number of documents which provide further details on how the Group will operate. They are the Group’s:

   i) Standing orders (Appendix C) – which sets out the arrangements for meetings and the appointment processes to elect the Group’s representatives and appoint to the Group’s committees, including the Governing Body

   ii) Scheme of reservation and delegation (Appendix D) – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the Group’s Governing Body, the Governing Body’s committees and sub-committees, the Group’s committees and sub-committees, individual members and employees

   iii) Prime financial policies (Appendix E) – which sets out the arrangements for managing the Group’s financial affairs
# APPENDIX A

**DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2006 Act</strong></td>
<td>National Health Service Act 2006</td>
</tr>
<tr>
<td><strong>2012 Act</strong></td>
<td>Health and Social Care Act 2012 (this Act amends the 2006 Act)</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td>Being answerable to others for what your actions</td>
</tr>
<tr>
<td><strong>Area</strong></td>
<td>the geographical area that the Group has responsibility for, as defined in Chapter 2 of this constitution</td>
</tr>
<tr>
<td><strong>Assistant Clinical Chair of the Governing Body</strong></td>
<td>the title given to the named individual who chairs meetings of the Governing Body in accordance with paragraph 7.3.1 of this constitution on occasions when the Chair is unable to attend the relevant meeting or part of it for reasons other than a conflict of interest.</td>
</tr>
<tr>
<td><strong>Chair of the Governing Body</strong></td>
<td>the individual appointed by the Group to act as chair of the Governing Body</td>
</tr>
</tbody>
</table>
| **Accountable Officer**                   | an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by NHS England, with responsibility for ensuring the Group:  
  - complies with its obligations under:  
    - sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),  
    - sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),  
    - paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and  
    - any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose;  
  - exercises its functions in a way which provides good value for money. |
| **Chief Financial Officer**               | the qualified accountant employed by the Group with responsibility for financial strategy, financial management and financial governance                                                                      |
| **Clinical commissioning Group**          | a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)                                                             |
| **Clinical Senate**                       | the Committee established in accordance with paragraphs 6.7.7 and 6.7.8 of this constitution                                                                                                               |
| **Committee / Sub-Committee**             | a committee created and appointed by:  
  - the membership of the Group                                                              |
| **Deputy Chair of the Governing Body** | The title given to the named individual who chairs meetings of the Governing Body in accordance with paragraph 7.3.1 of this constitution on occasions when the Chair has a conflict of interest and cannot participate in the relevant meeting or part of it. |
| **Financial year** | This usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning Group is established until the following 31 March. |
| **Group or CCG** | NHS Wirral Clinical Commissioning Group, whose constitution this is. |
| **Governing Body** | The body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning Group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and such generally accepted principles of good governance as are relevant to it. |
| **Governing Body member** | Any member appointed to the Governing Body of the Group. |
| **Lay member** | A lay member is an individual who is not a member of the Group or a healthcare professional (i.e., an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations. |
| **Member Practice** | A provider of primary medical services to a registered patient list, who is a member of this Group (see tables in Chapter 3 and Appendix B). |
| **Practice representatives** | An individual appointed by a practice (that is a Member Practice of the Group) to act on its behalf in the dealings between it and the Group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act). |
| **Registers of interests** | Registers a Group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by ...
section 25 of the 2012 Act), of the interests of the following members, staff and their close family:
- the members of the Group;
- the members of its Governing Body;
- the members of its committees or sub-committees and committees or sub-committees of its Governing Body; and its employees and their close family.

| Responsibility | The taking on of a task or role which you may or may not be accountable for. |
## APPENDIX B - LIST OF MEMBER PRACTICES

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>ADDRESS</th>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Day Health Centre</td>
<td>Arrove Park Hospital, Arrove Park Road, Upton, CH49 5PE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allport Surgery</td>
<td>43 Bridle Road, Bromborough, CH62 6EE</td>
<td></td>
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<tr>
<td>Blackheath Medical Centre</td>
<td>76 Reeds Lane, Leasowe CH46 1SG</td>
<td></td>
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<tr>
<td>Cavendish Medical Centre</td>
<td>Birkenhead Medical Building, 31 Laird Street, Birkenhead, Wirral CH41 8DB</td>
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<tr>
<td>Central Park Medical Centre</td>
<td>Victoria Central Health Centre, Mill Lane Wallasey CH44 5UF</td>
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<tr>
<td>Church Road Medical Practice</td>
<td>Higher Bebington Health Centre, 25 Brackenwood Road, Higher Bebington, Wirral CH63 2LR</td>
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<td>Civic Medical Centre</td>
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<tr>
<td>Claughton Medical Centre</td>
<td>161 Park Road North, Claughton, Birkenhead, Wirral CH41 0DD</td>
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<td>Commonfield Road Surgery</td>
<td>156 Commonfield Road, Woodchurch, Wirral CH49 7LP</td>
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<td>40 Balls Road, Oxton, Birkenhead, Wirral CH43 5RE</td>
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<td>1 Earlston Road Wallasey CH45 5DX</td>
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<td>Hamilton Medical Centre N85021</td>
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<td>Riverside Surgery N85016</td>
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<td>Silverdale Medical Centre N85058</td>
<td>Mount Avenue, Heswall, CH60 4RH</td>
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<td>Spital Surgery N85617</td>
<td>1 Lancelyn Court Precinct, Spital Road Bebington, Wirral CH63 9JP</td>
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<td>St George’s Medical Centre N85012</td>
<td>Field Road, Wallasey CH45 5LN</td>
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<td>Woodchurch Medical Centre</td>
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APPENDIX C – STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. These standing orders have been drawn up to regulate the proceedings of the NHS Wirral Clinical Commissioning Group so that the Group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the Group is established.

1.1.2. The standing orders, together with the Group’s scheme of reservation and delegation\textsuperscript{56} and the Group’s prime financial policies\textsuperscript{57}, provide a procedural framework within which the Group discharges its business. They set out:

a) the arrangements for conducting the business of the Group;

b) the appointment of member practice representatives to the Governing Body;

c) the procedure to be followed at meetings of the Group, the Governing Body and any committees or sub-committees of the Group or the Governing Body;

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate\textsuperscript{58} of any relevant guidance.

1.1.3. The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the Group’s constitution. Group members, employees, members of the Governing Body, members of the Governing Body’s committees and sub-committees, and persons working on behalf of the Group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

\textsuperscript{56} See Appendix D
\textsuperscript{57} See Appendix E
\textsuperscript{58} Under some legislative provisions the Group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.
1.2. Schedule of matters reserved to the clinical commissioning Group and the scheme of reservation and delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the Group with powers to delegate the Group’s functions and those of the Governing Body to certain bodies (such as committees) and certain persons. The Group has decided that certain decisions may only be exercised by the Group in formal session. These decisions and also those delegated are contained in the Group’s scheme of reservation and delegation (see Appendix D).

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESS

2.1. Composition of membership

2.1.1. Chapter 3 of the Group’s constitution provides details of the membership of the Group (also see Appendix B).

2.1.2. Chapter 6 of the Group’s constitution provides details of the governing structure used in the Group’s decision-making processes, whilst Chapter 7 of the constitution outlines certain key roles and responsibilities within the Group and its Governing Body, including the role of practice representatives (section 7.1 of the constitution).

2.2. Key Roles

2.2.1. Paragraph 6.6.2 of the Group’s constitution sets out the composition of the Group’s Governing Body whilst Chapter 7 of the Group’s constitution identifies certain key roles and responsibilities within the Group and its Governing Body. These standing orders set out how the Group appoints individuals to these key roles. All eligibility requirements include any requirements for specific roles laid down by law (in particular, the National health Service (Clinical Commissioning Groups) Regulations 2012), regardless of whether such requirements are stated in these standing orders or not.

2.2.2. The Chair of the Governing Body as listed in paragraph 6.6.2. of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – when the position is, or about to become vacant, GPs from a member practice of Wirral CCG interested in serving as Chair of the Group’s Governing Body should express their interest to the Director of Corporate Affairs, who will publish nomination and election process details at least two weeks in advance of a ballot, and circulate the list of candidates when nominations close.

b) **Eligibility** – candidates must be registered practising GPs, practising substantively (that is, not a locum) in one of the Group’s member practices. For the Chair of the Governing Body, the candidate must
disclose any criminal record, their GMC disciplinary record (including any fitness to practice issues) and any current or potential conflict of interest issues. A defined person specification outlining key competencies of the role will be developed and those wishing to stand must be able to demonstrate that they fulfill the requirements of this post. Candidates must have successfully completed as assessment process that has the support of NHS England in ensuring that the competencies and standards required are fully met.

c) Election process – the Director of Corporate Affairs will notify member practices of the candidates and their eligibility criteria, for the position of Chair and make arrangements to conduct a ballot over a period of not more than 21 days.

Voting will be based upon the member practices each casting a single weighted vote, with the weighting applied on the basis of 1 vote per 2,500 registered patients or part thereof. A mathematical representation and examples are set out below:

<table>
<thead>
<tr>
<th>Mathematical Representation</th>
<th>Number of registered patients</th>
<th>Weighted vote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$x$</td>
<td>$\left\lceil \frac{x}{2,500} \right\rceil$ (rounded up to the nearest whole number)</td>
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<td>Example 1</td>
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<td>Example 4</td>
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<tr>
<td>Example 5</td>
<td>10,001</td>
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The number of registered patients for each member practice will be determined with reference to the list of the patients maintained by NHS England as on the last day of the ballot.

Votes will be for a single candidate and cannot be split.

The results of the ballot, including a summary of voting analysed by candidate, will be recorded and made available to member practices, though individual votes will remain confidential. The candidate who receives the highest number of weighted votes will take the Chair at the next meeting of the Governing Body. In the event it is not possible to declare a single successful candidate, a second ballot will be conducted.
over a period of not more than 10 days between those two candidates who received the highest number of votes in the first ballot.

The Local Medical Committee shall be consulted on the election process and invited to observe elections.

d) **Term of office** – the Chair will serve for a period of 4 years, unless removed from office or resigning from the post.

e) **Eligibility for reappointment** – provided they meet the eligibility criteria at (b) above, GPs may put themselves forward for reappointment without limit on the number of terms served.

f) **Grounds for removal from office** – a GP serving as Chair will be automatically removed from office, without notice, in the event that s/he is removed from the List of Registered Medical Practitioners (note: removed from office temporarily, if suspended pending investigation), or ceases to practice in one of the Group’s member practices, or is not approved/accredited through NHS England or other assessment process(es) where that requirement is stipulated for the position.

A vote of no confidence by the majority of member practices via the Membership Council or by the majority of Governing Body voting members will also have the effect of removing the Chair from office without notice. If vacated, the Assistant Chair will immediately assume the Chair and remain in that position until a new Chair is appointed via the due process.

g) **Notice period** – a Chair wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the Deputy Chair, who will ask the Director of Corporate Affairs to initiate proceedings for an election without delay. Election proceedings to appoint a Chair after a completed term of office should be initiated by the Director of Corporate Affairs such that the newly-elected Chair may take office on completion of the term of his/her predecessor.

2.2.3. The **Medical Director** as listed in paragraph 6.6.2. of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – when the position is, or about to become vacant, GPs from a member practice of Wirral CCG interested in serving as Medical Director of the Group’s Governing Body should express their interest to the Director of Corporate Affairs, who will publish nomination and election process details at least two weeks in advance of a ballot, and circulate the list of candidates when nominations close.

b) **Eligibility** – candidates must be registered practising GPs, practising substantively (that is, not a locum) in one of the Group’s member practices. For the Medical Director role, the candidate must disclose any criminal record, their GMC disciplinary record (including any fitness to
practice issues) and any current or potential conflict of interest issues. A defined person specification outlining key competencies of the role will be developed and those wishing to stand must be able to demonstrate that they fulfill the requirements of this post. Candidates must have successfully completed as assessment to ensure that the competencies and standards required are fully met.

c) **Election process** – the Director of Corporate Affairs will notify member practices of the candidates and their eligibility criteria, for the position of Medical Director and make arrangements to conduct a ballot over a period of not more than 21 days.

Voting will be based upon the member practices each casting a single weighted vote, with the weighting applied on the basis of 1 vote per 2,500 registered patients or part thereof. A mathematical representation and examples are set out below:

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<td>Example 4</td>
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<td>4</td>
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<tr>
<td>Example 5</td>
<td>10,001</td>
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</tbody>
</table>

The number of registered patients for each member practice will be determined with reference to the list of the patients maintained by NHS England as on the last day of the ballot.

Votes will be for a single candidate and cannot be split.

The results of the ballot, including a summary of voting analysed by candidate, will be recorded and made available to member practices, though individual votes will remain confidential. The candidate who receives the highest number of weighted votes will take the Medical Director role at the next meeting of the Governing Body. In the event it is not possible to declare a single successful candidate, a second ballot will be conducted over a period of not more than 10 days between those two candidates who received the highest number of votes in the first ballot.
The Local Medical Committee shall be consulted on the election process and invited to observe elections.

d) **Term of office** – the Medical Director will serve for a period of 3 years, unless removed from office or resigning from the post.

e) **Eligibility for reappointment** – provided they meet the eligibility criteria at (b) above, GPs may put themselves forward for reappointment without limit on the number of terms served.

f) **Grounds for removal from office** – a GP serving as Medical Director will be automatically removed from office, without notice, in the event that s/he is removed from the List of Registered Medical Practitioners (note: removed from office temporarily, if suspended pending investigation), or ceases to practice in one of the Group’s member practices.

A vote of no confidence by the majority of member practices via the Membership Council or by the majority of Governing Body voting members will also have the effect of removing the Medical Director from office without notice.

g) **Notice period** – a Medical Director wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the Chair, who will ask the Director of Corporate Affairs to initiate proceedings for an election without delay. Election proceedings to appoint a Medical Director after a completed term of office should be initiated by the Director of Corporate Affairs such that the newly-elected Medical Director may take office on completion of the term of his/her predecessor.

2.2.4. The **GP Executive Lead – Primary Care** as listed in paragraph 6.6.2. of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – when the position is, or about to become vacant, GPs from a member practice of Wirral CCG interested in serving as GP Executive Lead – Primary Care of the Group’s Governing Body should express their interest to the Director of Corporate Affairs, who will publish nomination and election process details at least two weeks in advance of a ballot, and circulate the list of candidates when nominations close.

b) **Eligibility** – candidates must be registered practising GPs, practising substantively (that is, not a locum) in one of the Group’s member practices. For the GP Executive Lead – Primary Care role, the candidate must disclose any criminal record, their GMC disciplinary record (including any fitness to practice issues) and any current or potential conflict of interest issues. A defined person specification outlining key competencies of the role will be developed and those wishing to stand must be able to demonstrate that they fulfill the requirements of this post. Candidates must have successfully completed as assessment to ensure that the competencies and standards required are fully met.
c) **Election process** – the Director of Corporate Affairs will notify member practices of the candidates and their eligibility criteria, for the position of GP Executive Lead – Primary Care and make arrangements to conduct a ballot over a period of not more than 21 days.

Voting will be based upon the member practices each casting a single weighted vote, with the weighting applied on the basis of 1 vote per 2,500 registered patients or part thereof. A mathematical representation and examples are set out below:

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<th>Mathematical Representation</th>
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</thead>
<tbody>
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<td></td>
<td>( x )</td>
<td>( \frac{x}{2,500} ) (rounded up to the nearest whole number)</td>
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<td>Example 1</td>
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<td>4</td>
</tr>
<tr>
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<td>5</td>
</tr>
</tbody>
</table>

The number of registered patients for each member practice will be determined with reference to the list of the patients maintained by NHS England as on the last day of the ballot.

Votes will be for a single candidate and cannot be split.

The results of the ballot, including a summary of voting analysed by candidate, will be recorded and made available to member practices, though individual votes will remain confidential. The candidate who receives the highest number of weighted votes will take the GP Executive Lead – Primary Care role at the next meeting of the Governing Body. In the event it is not possible to declare a single successful candidate, a second ballot will be conducted over a period of not more than 10 days between those two candidates who received the highest number of votes in the first ballot.

The Local Medical Committee shall be consulted on the election process and invited to observe elections.

d) **Term of office** – the GP Executive Lead – Primary Care will serve for a period of 3 years, unless removed from office or resigning from the post.
e) **Eligibility for reappointment** – provided they meet the eligibility criteria at (b) above, GPs may put themselves forward for reappointment without limit on the number of terms served.

f) **Grounds for removal from office** – a GP serving as GP Executive Lead – Primary Care will be automatically removed from office, without notice, in the event that s/he is removed from the List of Registered Medical Practitioners (note: removed from office temporarily, if suspended pending investigation), or ceases to practice in one of the Group’s member practices.

A vote of no confidence by the majority of member practices via the Membership Council or by the majority of Governing Body voting members will also have the effect of removing the GP Executive Lead – Primary Care from office without notice.

g) **Notice period** – a GP Executive Lead – Primary Care wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the Chair, who will ask the Director of Corporate Affairs to initiate proceedings for an election without delay. Election proceedings to appoint a GP Executive Lead – Primary Care after a completed term of office should be initiated by the Director of Corporate Affairs such that the newly-elected GP Executive Lead – Primary Care may take office on completion of the term of his/her predecessor.

2.2.5. The **Accountable Officer**, as listed in paragraph 6.6.2. of the Group’s constitution, is subject to the following appointment process:

a) **Nominations** – an **Accountable Officer** must be appointed to the Governing Body, and will be the managing director of, and employed by, the Group. The post, when vacant, will be advertised in the usual manner and candidates must meet the attributes and competencies set out in the national role outlines guidance.

b) **Eligibility** – candidates must be able to demonstrate significant senior-level managerial experience, meet the attributes and competencies set out in the national role outlines guidance, meet any designated person specification of the job description, and have successfully completed as assessment process that has the support of NHS England in ensuring that the competencies and standards required are fully met.

c) **Appointment process** – a selection process will be devised and conducted by the Governing Body. The successful candidate’s appointment requires confirmation by NHS England.

d) **Term of office** – the Accountable Officer will serve for the duration of his/her employment.

e) **Eligibility for reappointment** – provided the post holder continues to meet the eligibility criteria at (b) above, and remains in employment with the Group, there is no reappointment process.

f) **Grounds for removal from office** – the post holder will be automatically removed from office, without notice, in the event that s/he fails to satisfy the
requirements of the defined assessment process(es), or, where employment is terminated by resignation, redundancy or as a result of disciplinary proceedings

g) Notice period – an Accountable Officer wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the Chair of the Governing Body, notwithstanding the notice requirements of the post holder’s employment

2.2.6. The GP Executive Lead – Planned Care, GP Executive Lead – Unplanned Care and GP Executive Lead – Long Term Conditions as listed in paragraph 6.6.2. of the Group’s constitution, are subject to the following appointment process

a) Nominations – The above Executive GP Leads will be appointed to the Governing Body, following a period of advertising for the post, applications and selection process

b) Eligibility – candidates must be able to demonstrate significant senior-level managerial and leadership experience, meeting any designated person specification or job description. They must be a practising substantively within a member practice of the Group

c) Appointment process – a selection process will be devised and conducted as a minimum by the Chair, the Accountable Officer and the Medical Director

d) Term of office – the Executive GP Leads will serve for the duration of his/her employment

e) Eligibility for reappointment – provided the post holder continues to meet the eligibility criteria at (b) above, and remains in employment with the Group, there is no reappointment process

f) Grounds for removal from office – the post holder will be automatically removed from office, without notice, in the event that s/he is removed or suspended from the relevant professional membership register, or where employment is terminated by resignation, redundancy or as a result of disciplinary proceedings

g) Notice period – a GP Executive Lead wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the Accountable Officer of the Governing Body; this applies notwithstanding any contrary notice requirements of the post holder’s contract of employment

2.2.7. Lay Members, as listed in paragraph 6.6.2. of the Group’s constitution, are subject to the following appointment process:

a) Nominations – Individuals interested in serving as lay members on the Governing Body will answer advertisements for such positions, or may be canvassed by local public bodies, including the Group, to make an application

b) Eligibility – candidates must be local residents, preferably residing in the Group’s area, and possess relevant skills and experience in the three areas
defined in 6.6.2 (which are: Audit and Governance, Patient Champion and Quality and Outcomes) which might enhance the Governing Body's deliberations, offering challenge to the clinicians and managers thereon, and enable a beneficial contribution to be made to the wider functioning of the Group, including leading on audit and governance, and on patient and public engagement and participation, for example. Candidates employed by the NHS, or with current clinical or associated interests or affiliations will not be considered as this might prompt conflicts of interest

c) **Appointment process** – a selection process will be conducted by the Chair and Accountable Officer using a process recommended in guidance from the NHS England. They may be assisted by colleagues or an external senior public official in their deliberations

d) **Term of office** – Lay Members will serve for four years, unless removed from office or resigning from the post

e) **Eligibility for reappointment** – provided the post holder continues to meet the eligibility criteria at (b) above, a Lay Members may serve without limit on the number of terms served

f) **Grounds for removal from office** – a Lay Members will be automatically removed from office, without notice, in the event of a majority vote of the Governing Body, duly convened, or if s/he is rendered ineligible through professional membership, affiliation or association, or employment with a primary or secondary care provider or supplier

g) **Notice period** – a Lay Advisor wishing to resign the post should give a minimum of 60 days' notice, in writing, addressed to the chair of the Governing Body

2.2.8. A **Secondary Care Specialist Doctor**, as listed in paragraph 6.6.2. of the Group’s constitution, is subject to the following appointment process

a) **Nominations** – a secondary care specialist will be appointed to the Governing Body, following a period of advertising for the post, the receipt of applications or recommendations and a robust selection process

b) **Eligibility** – candidates must be currently registered on the GMC Specialist Register, and be able to demonstrate significant professional and managerial experience, meeting any designated person specification or job description; candidates shall not be employed in any secondary care or other care provider capacity within the Group’s area with an employer from which the Group commissions significant supplies or services

c) **Appointment process** – a selection process will be devised by the Chair and Accountable Officer, who may enlist professional clinical support in their deliberations

d) **Term of office** – the secondary care specialist doctor will serve for four years, unless removed from office or resigning from the post
e) **Eligibility for reappointment** – provided the post holder continues to meet the eligibility criteria at (b) above, secondary care specialists may apply for reappointment without limit on the number of terms served.

f) **Grounds for removal from office** – the post holder will be automatically removed from office, without notice, in the event of a majority vote of the Governing Body, duly convened, or in the event that s/he is removed or suspended from the GMC Specialist Register.

g) **Notice period** – a secondary care specialist wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the chair of the Governing Body.

h) **Conflict of Interests:** Whilst the individual may well no longer practise medicine, they will need to demonstrate that they still have a relevant understanding of care in the secondary setting. The individual should not be employed by any organisation from which the CCG secures any significant volume of provision.

2.2.9. The **Director of Commissioning**, the **Director of Corporate Affairs** and the **Director of Quality and Patient Safety** as listed in paragraph 6.6.2 will continue as members of the CCG’s Governing Body as long as they remain employees of the Group. When vacant, these posts will be advertised in the usual manner.

2.2.10. The **Chief Financial Officer**, as listed in paragraph 6.6.2. of the Group’s constitution, is subject to the following appointment process.

a) **Nominations** – a Chief Financial Officer must be appointed to the Governing Body, and will be employed by the Group, or, under exceptional circumstances, an officer imposed by the NHS England for a fixed period, not exceeding six months; the post, when vacant, will be advertised in the usual manner.

b) **Eligibility** – candidates must be able to demonstrate significant senior-level financial and managerial experience, meeting any designated person specification or job description, be currently registered with a member body of the Consultative Committee of Accountancy Bodies and have successfully completed the NHS England assessment process, and any continuing process(es) for CCG top roles, and be a candidate acceptable to the NHS England.

c) **Appointment process** – a selection process will be devised and conducted as a minimum by the Chair, the Accountable Officer and the Chair of the Audit Committee.

d) **Term of office** – the Chief Financial Officer will serve for the duration of his/her employment.

h) **Eligibility for reappointment** – provided the post holder continues to meet the eligibility criteria at (b) above, and remains in employment with the Group, there is no reappointment process.

i) **Grounds for removal from office** – the post holder will be automatically removed from office, without notice, in the event that s/he is removed or
suspended from the relevant professional membership register, or fails to satisfy the requirements of the NHS England assessment process(es), or where employment is terminated by resignation, redundancy or as a result of disciplinary proceedings

j) **Notice period** – a Chief Financial officer wishing to resign the post should give a minimum of 60 days’ notice, in writing, addressed to the Clinical Chief Officer of the Governing Body, notwithstanding the notice requirements of the post holder’s employment

### 2.3 Disputes with member practices

In the event of a dispute arising between the CCG and a member practice the following process will be applied:

a) **Resolution at Head of Direct Commissioning:** In the first instance the practice should contact the Head of Direct Commissioning. In the event that the dispute cannot be resolved at this level or should the practice wish to appeal the decision then the dispute can be escalated to the Director of Commissioning

b) **Resolution at Director of Commissioning Level:** In the event that a dispute cannot be resolved at the Director of Commissioning Level, the Accountable Officer, supported by the Chief Finance Officer and Director of Corporate Affairs where necessary, will attempt to resolve the dispute.

c) **Appeal to the CCG Chair:** In the event that a dispute remains unresolved the practice has a right of appeal to the CCG chair. Under such circumstances the chair will convene an dispute panel that will consist of

- CCG Chair
- Lay Member – Audit and Governance
- Lay Member– Patient Champion

d) In the rare event that a dispute cannot be resolved through these local mechanisms the practice can refer the case to the Local Area Team of NHS England
3. **MEETINGS OF THE CLINICAL COMMISSIONING GROUP**

3.1. **Membership of the Clinical Commissioning Group**

3.1.1. Ordinary meetings of the Group shall be held at regular intervals at such times and places as the Group may determine.

3.1.2. Meetings of the Governing Body shall normally be held in public, scheduled in advance, and the date, time and location publicised on the Group’s website and other media. No fewer than six meetings shall be held annually, and these scheduled meetings will be agreed by the Governing Body in advance of each financial year.

3.1.3. Unscheduled meetings of the Governing Body can also be called by

a) the Chair, in the event that urgent business prompts convening a meeting ('special' meeting), by giving at least 7 days' notice thereof

b) written request, from at least 1/3rd members of the Governing Body ('extraordinary' meeting), requiring a meeting to be convened within 14 days in either event, the Director of Corporate Affairs will notify all members of the Governing Body by post or email, indicating the purpose and likely duration of the meeting, indicating date, time and venue, giving at least 7 days' notice. The conduct of confidential business shall warrant a closed meeting, or closed session of a meeting held in public, and the Chair shall require only members of the Governing Body and any person(s) invited for the purpose of discussing the confidential matter(s) to be present.

3.1.4. All meetings of the Governing Body shall be preceded by the distribution at least seven days in advance of the meeting to its members and the general public via approved methods (see meetings policy for details) of an agenda and supporting papers. Papers may only be tabled at a meeting under exceptional circumstances and by agreement from the Chair. The Chair will determine the time allocated for each agenda item and has sole discretion in this respect. Public comment and questions will be allowed during a ten minute period at the start of the meeting after any declarations of interest have been raised.

3.1.5. Meetings of the Group’s Audit Committee shall be held at regular intervals at such times and places as the Group may determine, but not less than five times annually, against a schedule agreed by members of that committee. The Chair of the Audit Committee may call additional meetings as required by the business of the Group, giving at least 14 days' notice.

3.1.6. Meetings of the Group’s Remuneration committee shall be held at regular intervals at such times and places as the Group may determine, occasioned by the needs of the Group or the requirement to provide advice to the Governing Body. The Chair of the Committee will call meetings as required, giving at least 5 days’ notice.

3.2. **Agenda, supporting papers and business to be transacted**

3.2.1. Items of business for inclusion on the agenda of a meeting of the Governing Body should be notified to the Director of Corporate Affairs at least 10 working
days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 8 working days before the meeting takes place. The agenda and supporting papers should normally be published on the CCG website (see below) and circulated to all members of a meeting 5 working days, but not less than 3 working days, before the date the meeting will take place.

3.2.2. Details of the dates, times and venues of meetings of the Group’s Governing Body will be published, including in the Group’s Member Practices’ premises. Agendas and all of the non private papers for meetings of the Group’s Governing Body, including details about dates, times and venues, will be published on the Group’s website at [http://www.wirralccg.nhs.uk/](http://www.wirralccg.nhs.uk/) and as detailed in the Group’s publication policy.

3.3. Petitions

3.3.1. Where a petition has been received by the Group, the Chair of the Governing Body shall include the petition as an item for the agenda of the next meeting of the Governing Body.

3.4. Chair of a meeting

3.4.1. At any meeting of the Group or its Governing Body or of a committee, sub-committee or sub-Group, the Chair of the Group, Governing Body, committee, sub-committee or sub-Group, if any and if present, shall preside. If the Chair is absent from the meeting, the Assistant Chair, if present, shall preside.

3.4.2. If the Chair is absent temporarily on the grounds of a declared conflict of interest the Lay Member Governance if present, shall preside. If both the Chair and Lay Member Governance are absent the Chair shall be taken by the Lay Member Patient Champion. If neither of these are available, a participating member of the particular meeting shall be chosen as acting Chair by the members present provided that such a member is available and not subject to a conflict of interest. In the event of there being no available member who is not subject to a conflict of interest, the issue giving rise to the conflict of interest shall not be discussed and shall be deferred to another occasion when one of the Lay Members are available.

3.5. Chair’s ruling

3.5.1. The decision of the Chair of the Governing Body on questions of order, relevancy and regularity and on interpretation of the constitution, standing orders, conflicts of interest, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

3.6. Quorum

3.6.1. Meetings of the Governing Body shall be quorate provided there are no fewer than five voting members present, including the Chair or Deputy Chair (unless absent due to a conflict of interest) and at least two other GP Executive Leads,
3.6.2. Where an issue cannot be resolved due to problems of quoracy, guidance to enable the issue to be progressed is available under section 8.4.1 of the Group’s constitution. Decisions reached under those alternative arrangements are binding on the Group.

3.6.3. Unless the Governing Body has been constituted and convened for the specific purpose of resolving an issue (following guidance under the constitution section 8.4.1), which otherwise could not be dealt with because conflicts of interest disqualified members from participating, deputies or attendees representing a particular member of the Governing Body may speak but cannot vote on any issue.

3.6.4. For all other of the Group’s committees, sub-committees and sub-Groups, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference.

3.7. Emergency powers and urgent decisions

3.7.1. Subject to the agreement of the Chair, a member of the Governing Body may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Governing Body at the commencement of the business of the meeting as an additional item included on the agenda. The Chair’s decision to include the item shall be final.

3.7.2. The powers which the Governing Body has reserved to itself within these Standing Orders may in emergency or for an urgent decision be jointly exercised by the chair and the Accountable Officer after having consulted, and obtained the agreement of, at least one representative member and one Lay Advisor – if available the Lay Advisor – Audit and Governance. The exercise of such powers shall be reported to the next formal meeting of the Governing Body in public session for ratification.

3.8. Suspension of Standing Orders

3.8.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these standing orders may be suspended at any meeting, provided half the Group members are in agreement.

3.8.2. A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

3.8.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body’s audit committee for review of the reasonableness of the decision to suspend standing orders.

3.8.4. Suspended Standing Orders will be reviewed by the Audit Committee within six months of the suspension occurring.
3.9. **Application for variation and amendment of Standing Orders**

3.9.1. This constitution can only be varied in two circumstances:

   a) where the CCG formally applies to NHS England and that application is granted

   b) where in the circumstances set out in legislation NHS England varies the CCG’s constitution other than on application by the CCG

3.9.2. Any variation of the Constitution will be communicated to all members, stakeholders and the public via the approved communications outlets and the CCG website with two weeks’ notice.

3.9.3. Standing Orders will be reviewed at least annually

3.10. **Record of Attendance**

3.10.1. The names of all members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all members of the Governing Body’s committees / sub-committees present shall be recorded in the minutes of the respective Governing Body committee / sub-committee meetings.

3.11. **Minutes**

3.11.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it as a true record.

3.11.2. No discussion shall take place upon the minutes except upon their accuracy or matters arising where the Chair considers discussion appropriate.

3.11.3. Minutes of meetings held in public shall be made available to members and the public via the CCG website and through the other approved communications methods as detailed in the CCG’s publication policy

3.11.4. Further guidance on taking and writing minutes can be found in the Meetings policy available on the CCG website [http://www.wirralccg.nhs.uk](http://www.wirralccg.nhs.uk/) and as detailed in the CCG’s publication policy

3.12. **Admission of public and the press**

3.12.1. **Admission and exclusion on grounds of confidentiality of business to be transacted**

   i) All formal meetings of the CCG Governing Body will be open to the general public.

   ii) The CCG will agree and publicise criteria for exclusion of business from the public part of any meeting.

   iii) The public and representatives of the press may attend all meetings of the CCG or its Governing Body held in public, and should only be
required to withdraw from these meetings where any information being shared is exempt from publication under the agreed criteria.

iv) The public and representatives of the press shall be required to withdraw upon a resolution as follows:

‘that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’, Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

3.12.2. Business proposed to be transacted when the press and public have been excluded from a meeting

i) Matters to be dealt with by the CCG or its Governing Body following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the CCG.

ii) Members of the CCG and Officers or any employee of the CCG in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the meeting, without the express permission of the Governing Body. This prohibition shall apply equally to the content of any discussion during the Governing Body meeting which may take place on such reports or papers.

iii) Minutes will be taken during this part of a meeting and will be marked confidential.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1. Appointment of committees and sub-committees

4.1.1. The Group may appoint committees and sub-committees of the Governing Body, subject to any regulations made by the Secretary of State\(^59\). Where such committees and sub-committees of the Governing Body, are appointed they are included in Chapter 6 of the Group’s constitution.

4.1.2. Other than where there are statutory requirements, such as in relation to the Governing Body’s audit committee or remuneration committee, the Group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the Governing Body of the Group.

4.1.3. The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body’s committees and sub-committee and all committees and sub-committees unless stated otherwise in the committee or sub-committee’s terms of reference.

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\(^{59}\) See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act
4.2. **Terms of Reference**

4.2.1. Terms of reference shall have effect as if incorporated into the constitution and shall be added to this document as appendices.

4.3. **Delegation of Powers by Committees to Sub-committees**

4.3.1. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Governing Body.

4.4. **Approval of Appointments to Committees and Sub-Committees**

4.4.1. The Governing Body shall approve the appointments to each of the committees and sub-committees which it has formally constituted and shall agree such travelling or other allowances as it considers appropriate.

5. **DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES**

5.1. If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Governing Body for action or ratification. All members of the Group and staff have a duty to disclose any non-compliance with these standing orders to the Chief Clinical Officer as soon as possible.

6. **USE OF SEAL AND AUTHORISATION OF DOCUMENTS**

6.1. **Clinical Commissioning Group’s seal**

6.1.1. The Group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

   a) the Accountable Officer;
   b) the Chair of the Governing Body;
   c) the Chief Financial Officer;

6.2. **Execution of a document by signature**

6.2.1. The following individuals are authorised to execute a document on behalf of the Group by their signature.

   a) the Accountable Officer
   b) the Chair of the Governing Body
c) the Chief Financial Officer

7. OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1. Policy statements: general principles

7.1.1. The Group will from time to time agree and approve policy statements / procedures which will apply to all or specific Groups of staff employed by NHS Wirral Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate Group minute and will be deemed where appropriate to be an integral part of the Group’s standing orders.
### APPENDIX D – SCHEME OF RESERVATION & DELEGATION

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Reserved or Delegated Matter</th>
<th>Matter Reserved to the Membership</th>
<th>Matter Reserved to the Governing Body</th>
<th>Delegated To</th>
<th>Responsible for Recommending a course of action</th>
<th>Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>REGULATION AND CONTROL</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.</td>
<td>Member practices</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>1.2</td>
<td>Consideration and approval of applications to NHS England on matters concerning changes to the group’s constitution, including terms of reference for the group’s Governing Body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Chair</td>
</tr>
<tr>
<td>1.3</td>
<td>Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group or delegated to the Governing Body or to a committee or sub-committee of the group or to one of its members or employees.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>1.4</td>
<td>Approval of the group’s overarching scheme of reservation and delegation, which sets out those decisions that are in statute the responsibility of the group and that are reserved to the membership and those delegated to the group’s Governing Body</td>
<td>N/A</td>
<td>Governing body</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

NHS Wirral Clinical Commissioning Group’s Constitution
Version: 1.6
<table>
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<tr>
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<th>Responsible for Recommending a course of action</th>
<th>Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>• committees, sub-committees, or advisory panels of the group or its members or employees</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>1.6</td>
<td>Prepare the groups <em>overarching</em> scheme of reservation and delegation, which sets out those decisions that are in statute the responsibility of the Governing Body are reserved to the Governing Body and those delegated to the • Governing Body’s committees and sub-committees, • members of the Governing Body, • an individual who is member of the group but not the Governing Body or a specified person</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>All Staff</td>
</tr>
<tr>
<td>1.7</td>
<td>Disclosure of non-compliance with the group’s constitution (incorporating its standing orders, prime financial policies and scheme of reservation and delegation)</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>1.8</td>
<td>Suspension of standing orders (appendix c para 3.8)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>1.9</td>
<td>Review of suspension of standing orders</td>
<td>N/A</td>
<td>N/A</td>
<td>Audit Committee</td>
<td>N/A</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>1.10</td>
<td>Approval of the group’s <em>operational</em> scheme of delegation that underpins the group’s ‘overarching scheme of reservation and delegation’ as set out in the constitution</td>
<td>N/A</td>
<td>Governing body</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Prepare the group’s <em>operational</em> scheme of delegation, which sets out those key decisions</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>Ref No</td>
<td>Reserved or Delegated Matter</td>
<td>Matter Reserved to the Membership</td>
<td>Matter Reserved to the Governing Body</td>
<td>Delegated To Committee</td>
<td>Individual Member or Officer</td>
<td>Responsible for Recommending a course of action</td>
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<td></td>
<td>delegated to individual employees of the CCG not for inclusion in the constitution</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>1.11</td>
<td>Approve the group’s prime financial policies</td>
<td>N/A</td>
<td>N/A</td>
<td>Quality Performance and Finance Committee</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>1.12</td>
<td>Approve detailed financial procedures</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>1.13</td>
<td>Approve arrangements for managing exceptional funding requests</td>
<td>N/A</td>
<td>Governing body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>1.14</td>
<td>Set out who can execute a document by signature / use of the seal</td>
<td>N/A</td>
<td>Governing body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>2a</td>
<td>PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY</td>
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<tr>
<td>2.1</td>
<td>Approve the arrangements for</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Chair(Accountable Officer)</td>
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<tr>
<td></td>
<td>- identifying practice members to represent practices in matters concerning the work of the group; and</td>
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<td></td>
<td>- appointing clinical leaders to represent the group’s membership on the group’s Governing Body.</td>
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<tr>
<td>2.2</td>
<td>Approve the appointment of Governing Body members.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Chair</td>
<td></td>
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</tr>
<tr>
<td>2b</td>
<td>MEMBERS OF THE GOVERNING BODY</td>
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</tr>
<tr>
<td>2.3</td>
<td>Approve the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Chair</td>
</tr>
<tr>
<td>Ref No</td>
<td>Reserved or Delegated Matter</td>
<td>Matter Reserved to the Membership</td>
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<td>Individual Member or Officer</td>
<td>Responsible for Recommending a course of action</td>
<td>Operational Responsibility</td>
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<tr>
<td>2.4</td>
<td>Approve arrangements for recruiting the group’s accountable officer.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Chair</td>
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<td></td>
<td>Director of Corporate Affairs</td>
</tr>
<tr>
<td>3</td>
<td>STRATEGY AND PLANNING</td>
<td></td>
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</tr>
<tr>
<td>3.1</td>
<td>Approve the vision, values and overall strategic direction of the group.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<td>Accountable Officer</td>
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<tr>
<td>3.2</td>
<td>Approve the group’s operating structure</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<td>Accountable Officer</td>
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<tr>
<td>3.3</td>
<td>Approve the group’s commissioning plan</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<td>Accountable Officer</td>
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<tr>
<td>3.4</td>
<td>Approve the group’s arrangements for engaging the public and key stakeholders in the group’s planning and commissioning arrangements.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<td>Accountable Officer</td>
</tr>
<tr>
<td>3.5</td>
<td>Approve the group’s corporate budgets that meet the financial duties of the group.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<tr>
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<td></td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>3.6</td>
<td>Approve variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group’s ability to achieve its agreed strategic aims</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<td></td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>4</td>
<td>ANNUAL REPORTS AND ACCOUNTS</td>
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<td></td>
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<tr>
<td>4.1</td>
<td>Approval of the group’s annual report and annual accounts</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Audit committee</td>
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<td></td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>4.2</td>
<td>Approval of the arrangements for discharging the group’s statutory financial duties</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<td></td>
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<td></td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>5</td>
<td>HUMAN RESOURCES &amp; ORGANISATIONAL DEVELOPMENT</td>
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NHS Wirral Clinical Commissioning Group’s Constitution
Version: 1.6
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<th>Ref No</th>
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<th>Delegated To</th>
<th>Individual Member or Officer</th>
<th>Responsible for Recommending a course of action</th>
<th>Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Remuneration Committee</td>
<td>N/A</td>
<td>Remuneration Committee</td>
<td>Chair</td>
</tr>
<tr>
<td>5.2</td>
<td>Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Remuneration Committee</td>
<td>N/A</td>
<td>Remuneration Committee</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>5.3</td>
<td>Approve any other terms and conditions of services for the group’s employees</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Remuneration Committee</td>
<td>N/A</td>
<td>Remuneration Committee</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>5.4</td>
<td>Approve disciplinary arrangements for employees, including the accountable officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Remuneration Committee</td>
<td>N/A</td>
<td>Remuneration Committee</td>
<td>Accountable Officer (excluding own post)</td>
</tr>
<tr>
<td>5.5</td>
<td>Approve disciplinary arrangements where the group has joint appointments with another group and the individuals are employees of that group.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Remuneration Committee</td>
<td>N/A</td>
<td>Remuneration Committee</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>5.6</td>
<td>Approval of the arrangements for discharging the group’s statutory duties as an employer.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Director of Corporate Affairs</td>
<td>Director of Corporate Affairs</td>
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<tr>
<td>5.7</td>
<td>Approve human resources policies for employees and for other persons working on behalf of the group.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Director of Corporate Affairs</td>
<td>Director of Corporate Affairs</td>
</tr>
<tr>
<td>6</td>
<td>QUALITY AND SAFETY</td>
<td></td>
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</tr>
<tr>
<td>6.1</td>
<td>Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Quality, Performance and Finance Committee</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Director of Quality &amp; Patient Safety</td>
</tr>
<tr>
<td>Ref No</td>
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</tr>
<tr>
<td>6.2</td>
<td>Approve the group’s arrangements for handling complaints, Freedom of Information, clinical concerns requests.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Quality, Performance and Finance Committee</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Director of Corporate Affairs</td>
</tr>
<tr>
<td>6.3</td>
<td>Approve the group’s arrangements for safeguarding children and vulnerable adults.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Head of Quality &amp; Performance</td>
<td>Director of Quality &amp; Patient Safety</td>
</tr>
<tr>
<td>6.4</td>
<td>Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>GP Executive Primary Care</td>
<td>Accountable Officer</td>
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<tr>
<td>7</td>
<td>OPERATIONAL AND RISK MANAGEMENT</td>
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<td></td>
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</tr>
<tr>
<td>7.1</td>
<td>Approve the group’s counter fraud and security management arrangements.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>7.2</td>
<td>Approval of the group’s risk management arrangements</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>7.3</td>
<td>Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of the NHS Act 2006).</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>7.4</td>
<td>Approve a comprehensive system of internal control, including budgetary control that underpins the effective, efficient and economic operation of the group.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>7.5</td>
<td>Approve the thresholds above which quotations or formal tenders must be obtained</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
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</tr>
<tr>
<td>7.6</td>
<td>Approve the arrangements for seeking professional advice regarding the supply of goods and services.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>7.7</td>
<td>Approve proposals for action on litigation against or on behalf of the clinical commissioning group</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>7.8</td>
<td>Approve the group's arrangements for business continuity and emergency planning</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Director of Corporate Affairs</td>
</tr>
</tbody>
</table>

**8 INFORMATION GOVERNANCE**

| 8.1    | Approve the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data. | N/A                        | Governing Body                | N/A                    | N/A                         | Accountable Officer                        | Chief Finance Officer (SiRO) |
| 8.2    | Approve information sharing protocols with other organisations                                | N/A                        | Governing Body                | N/A                    | N/A                         | Accountable Officer                        | Chief Finance Officer (SiRO) |

**9 PARTNERSHIP, JOINT OR COLLABORATIVE WORKING**

<p>| 9.1    | Approve the arrangements governing joint or collaborative arrangements between the group and another statutory body(ies), where those arrangements incorporate decision making responsibilities. | N/A                        | Governing Body                | N/A                    | N/A                         | Accountable Officer                        | Accountable Officer        |
| 9.2    | Approve the delegated decision making responsibilities of individual members or employees of the group who represent the group in joint or collaborative arrangements with another statutory body(ies) | N/A                        | Governing Body                | N/A                    | N/A                         | Accountable Officer                        | Accountable Officer        |
| 9.3    | Authorise an individual to act on behalf of the group                                         | N/A                        | Governing Body                | N/A                    | N/A                         | Accountable Officer                        |                           |</p>
<table>
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<tr>
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<th>Operational Responsibility</th>
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<tbody>
<tr>
<td>10.1</td>
<td>Approve the group’s procurement arrangements for any Part A services (e.g. Payroll, consumables, equipment, commissioning support)</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<tr>
<td>10.2</td>
<td>Approve the group’s procurement arrangements for any Part B Services (Health and Social Care)</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<tr>
<td>10.3</td>
<td>Approval of the Groups delegated limits for procurement, tenders and quotations.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>10.4</td>
<td>Consider any appropriate proposals that may present a potential conflict of interest.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Approvals Committee</td>
<td>N/A</td>
<td>Approvals Committee</td>
</tr>
<tr>
<td>10.5</td>
<td>Waiving the requirement for competitive tender (Single Tender Action) or quotation (Refer to <a href="http://www.commissioningboard.nhs.uk/files/2012/09/procure-brief-2.pdf">http://www.commissioningboard.nhs.uk/files/2012/09/procure-brief-2.pdf</a>)</td>
<td>N/A</td>
<td>Governing Body</td>
<td>Audit Committee</td>
<td>N/A</td>
<td>Accountable Officer</td>
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<th>Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Approve the arrangements for discharging the group’s statutory duties associated with its commissioning functions.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>11.2</td>
<td>Approve arrangements (including where appropriate, an individual’s authority to act) for co-ordinating the commissioning of services with the local authority(s) and other Clinical Commissioning Groups.</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>11.3</td>
<td>Approval of contracts for clinical services with a value in excess of £150,000,000 (Also see 10.2 above)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
<td>Refer to Operational Delegated Limits</td>
</tr>
<tr>
<td>11.4</td>
<td>Approve contracts for clinical services with a value less than £150,000,000 (Also see 10.2 above)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Chief Financial Officer</td>
<td></td>
<td>Refer to Operational Delegated Limits</td>
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<tr>
<td>12</td>
<td>COMMISSIONING AND CONTRACTING FOR NON-CLINICAL SERVICES (Also see 10.1 above)</td>
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<tr>
<td>12.1</td>
<td>Approve arrangements for co-ordinating the commissioning of non-clinical services with other groups</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>12.2</td>
<td>Approve arrangements for co-ordinating the commissioning of non-clinical services with local authority(ies)</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>12.3</td>
<td>Approval of contracts for non-clinical services with a value in excess of £250,000</td>
<td>N/A</td>
<td>Governing Body</td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
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<tr>
<td>12.4</td>
<td>Approve contracts for non-clinical services with a value less than <strong>£250,000</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>Accountable Officer</td>
<td>Accountable Officer</td>
<td>Refer to Operational Delegated Limits</td>
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</tbody>
</table>
APPENDIX E – PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the Group’s constitution.

1.1.2. The prime financial policies are part of the Group’s control environment for managing the organisation’s financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration and lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Financial Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found at Appendix D.

1.1.3. In support of these prime financial policies, the Group has prepared more detailed policies, approved by the Accountable Officer / Chief Financial Officer – Clinical Commissioning Group to select, known as detailed financial policies. The Group refers to these prime and detailed financial policies together, as the clinical commissioning Group’s financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Accountable Officer and the Chief Financial Officer are responsible for approving all detailed financial policies.

1.1.5. A list of the Group’s detailed financial policies will be published and maintained on the Group’s website at http://www.wirralccg.nhs.uk/

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Accountable Officer or the Chief Financial Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the Group’s constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Governing Body’s audit committee for referring action or ratification. All of the Group’s members and employees have a duty to disclose
any non-compliance with these prime financial policies to the Chief Financial Officer as soon as possible.

1.3. **Responsibilities and delegation**

1.3.1. The roles and responsibilities of the Group’s members, employees, members of the Governing Body, members of the Governing Body’s committees and sub-committees, members of the Group’s committee and sub-committee (if any) and persons working on behalf of the Group are set out in chapters 6 and 7 of this constitution.

1.3.2. The financial decisions delegated by the Group’s Governing Body are set out in the Group’s scheme of reservation and delegation (see Appendix D).

1.4. **Contractors and their employees**

1.4.1. Any contractor or employee of a contractor who is empowered by the Group to commit the Group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Clinical Officer to ensure that such persons are made aware of this.

1.5. **Amendment of Prime Financial Policies**

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Chief Financial Officer will review them at least annually. Following consultation with the Accountable Officer and scrutiny by the Governing Body’s Audit Committee, the Chief Financial Officer will recommend amendments, as fitting, to the Governing Body for approval. As these prime financial policies are an integral part of the Group’s constitution, any amendment will not come into force until the Group applies to NHS England and that application is granted.

2. **INTERNAL CONTROL**

**Policy**

The Group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

2.1. The Governing Body is required to establish an audit committee with terms of reference agreed by the Governing Body (see paragraph 6.7.1 of the Group’s constitution for further information).

2.2. The Accountable Officer has overall responsibility for the Group’s systems of internal control.

2.3. The Chief Financial Officer will ensure that:

a) financial policies are considered for review and updated annually;
b) a system is in place for proper checking and reporting of all breaches of financial policies; and

c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. **AUDIT**

**Policy**

The Group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1. In line with the terms of reference for the Governing Body’s Audit Committee, the person appointed by the Group to be responsible for internal audit and appointed external auditor will have direct and unrestricted access to Audit Committee members and the Chair of the Governing Body, Accountable Officer and Chief Financial Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.2. The person appointed by the Group to be responsible for internal audit and the external auditor will have access to the Audit Committee and the Accountable Officer to review audit issues as appropriate. All Audit Committee members, the Chair of the Governing Body and the Accountable Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.3. The Chief Financial Officer will ensure that:

   a) the Group has a professional and technically competent internal audit function

   b) the Governing Body / Governing Body’s Audit Committee approves any changes to the provision or delivery of audit services to the Group

4. **FRAUD AND CORRUPTION**

**Policy**

The Group requires all staff to always act honestly and with integrity to safeguard the public resources for which they are responsible. The Group will not tolerate any fraud perpetrated against the population who fund the NHS and will actively chase any loss suffered

4.1. The Governing body shall ensure that its members and, as far as reasonably practicable the CCG as a whole, conduct all business with due consideration of general duties and obligations arising from the bribery Act 2010.
4.2. The Governing Body’s Audit Committee will satisfy itself that the Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

4.3. The Governing Body’s Audit Committee will ensure that the Group has arrangements in place to work effectively with NHS Protect for more see http://www.nhsbsa.nhs.uk/protect.aspx

5. EXPENDITURE CONTROL

5.1. The Group is required by statutory provisions\(^{60}\) to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the Group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The Chief Financial Officer will:

a) provide reports in the form required by NHS England;

b) ensure money drawn from NHS England is required for approved expenditure only and is drawn down only at the time of need and follows best practice;

c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS\(^{61}\)

6.1. The Group’s Chief Financial Officer will:

a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the Group’s entitlement to funds;

b) prior to the start of each financial year submit to the Governing Body for approval, a report showing the total allocations received and their proposed distribution including any sums to be held in reserve;

c) regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

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\(^{60}\) See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{61}\) See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

Policy

The Group will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The Group will support this with comprehensive medium term financial plans and annual budgets.

7.1. The Accountable Officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body.

7.3. The Accountable Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report should include explanations for variances. These variance reports will identify on any significant departures from agreed financial plans or budgets.

7.4. The Accountable Officer is responsible for ensuring that information relating to the Group’s accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

7.5. The Accountable Officer will approve consultation arrangements for the Group’s commissioning plan.

8. ANNUAL ACCOUNTS AND REPORTS

Policy

The Group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.1. The Chief Financial Officer will ensure the Group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body

b) prepares the accounts according to the timetable approved by the Governing Body

c) complies with statutory requirements and relevant directions for the publication of an annual report.

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d) considers the external auditor’s management letter and fully address all issues within agreed timescales

e) publishes the external auditor’s management letter on the Group's website at http://www.wirralccg.nhs.uk/ once reviewed by the Governing Body

9. INFORMATION TECHNOLOGY

Policy

The Group will ensure the accuracy and security of the Group’s computerised financial data

9.1. The Chief Financial Officer is responsible for the accuracy and security of the Group's computerised financial data and shall

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Group's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Financial Officer may consider necessary are being carried out

9.2. In addition the Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

Policy

The Group will run an accounting system that creates management and financial accounts

10.1. The Chief Financial Officer will ensure:
a) the Group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, the contract should also ensure rights of access for audit purposes

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

Policy
The Group will keep enough liquidity to meet its current commitments

11.1. The Chief Financial Officer will:

a) review the banking arrangements of the Group at regular intervals to ensure they are in accordance with Secretary of State directions63, best practice and represent best value for money

b) manage the Group's banking arrangements and advise the Group on the provision of banking services and operation of accounts

c) prepare detailed instructions on the operation of bank accounts

11.2. The Accountable Officer shall approve the banking arrangements.

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63 See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act
12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS.

Policy - the Group will
• operate a sound system for prompt recording, invoicing and collection of all monies due
• seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the Group or its functions
• ensure its power to make grants and loans is used to discharge its functions effectively

12.1. The Chief Financial Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due
b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments
c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute, independent professional advice on matters of valuation shall be taken as necessary
d) for developing effective arrangements for making grants or loans

13. TENDERING AND CONTRACTING PROCEDURE

Policy– the Group:
• will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
• will seek value for money for all goods and services
• shall ensure that competitive tenders are invited for
  o the supply of goods, materials and manufactured articles;
  o the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
  o for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals
13.1. The Group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Financial Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer or the Group’s Governing Body.

13.2. The Governing Body may only negotiate contracts on behalf of the Group, and the Group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the Group’s standing orders

b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law

c) and take into account as appropriate, any applicable NHS Commissioning Board or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above

13.3. In all contracts entered into, the Group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the Group.

14. COMMISSIONING

Policy

Working in partnership with relevant national and local stakeholders, the Group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1. The Group will coordinate its work with NHS England, other clinical commissioning Groups, local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary, community and faith sector and others as appropriate to develop robust commissioning plans.

14.2. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

14.3. The Chief Financial Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.
15. RISK MANAGEMENT AND INSURANCE

Policy
The Group will put arrangements in place for evaluation and management of its risks

15.1. The Accountable Officer has overall accountability for Risk Management within the CCG and the Governing Body demonstrates commitment through the endorsement of the Risk Management Strategy.

15.2. The Board of each level sub-committee is responsible for identifying, assessing, evaluating, treating, monitoring and recording risks as set out in their Risk Management policy. Following assessment, all identified high or complex risks that cannot be controlled within the respective area will be escalated to the NHS Wirral CCG Corporate Risk Register.

15.3. The Board of the Audit Committee will review and monitor those risks escalated from sub committees along with all other risks entered onto the Corporate Risk Register. A quarterly report will be sent to the Governing Body for review, with risks identified as requiring urgent attention being forwarded for the next meeting. The Audit Committee will also be responsible for ensuring that the Risk assurance procedures are being followed and reviewed on an annual basis.

15.4. The Governing Body will receive the quarterly reports from the Audit Committee and where necessary will provide guidance on the actions to be taken for all risks identified as requiring urgent attention which have been forwarded on from the Audit Committee. The Governing Body will also review the Corporate Risk Register on a monthly basis to ensure appropriate actions have been carried out.

16. PAYROLL

Policy
The Group will put arrangements in place for an effective payroll service

16.1. The Chief Financial Officer will ensure that the payroll service selected:
   a) is supported by appropriate (i.e. contracted) terms and conditions
   b) has adequate internal controls and audit review processes
   c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies

16.2. In addition the Chief Financial Officer shall set out comprehensive procedures for the effective processing of payroll
17. NON-PAY EXPENDITURE

Policy
The Group will seek to obtain the best value-for-money goods and services received

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers

17.2. The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Financial Officer will:
   a) advise the Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;
   b) be responsible for the prompt payment of all properly authorised accounts and claims;
   c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Policy
The Group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the Group’s fixed assets

18.1. The Accountable Officer will
   a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans
   b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost
   c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges
18.2. The CCG shall maintain a registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.3. The Chief Financial Officer will prepare detailed procedures for the disposals of assets.

19. **RETENTION OF RECORDS**

**Policy**

The Group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

19.1. The Accountable Officer shall:

a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

b) ensure that arrangements are in place for effective responses to Freedom of Information requests

c) publish and maintain a Freedom of Information Publication Scheme

20. **TRUST FUNDS AND TRUSTEES**

**Policy**

The Group will put arrangements in place to provide for the appointment of trustees if the Group holds property on trust

20.1. The Chief Financial Officer shall ensure that each trust fund which the Group is responsible for managing, is managed appropriately with regard to its purpose and to its requirements.
1. The ‘Nolan Principles’ set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

APPENDIX G – NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **The NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to Groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. **Access to NHS services is based on clinical need, not an individual’s ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. **The NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. **The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being.

6. **The NHS is committed to providing best value for taxpayers’ money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. **The NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

Source: The NHS Constitution: The NHS belongs to us all (March 2012)65

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APPENDIX H – TERMS OF REFERENCE

Including

1. Audit Committee
2. Remuneration Committee
3. Quality, Performance & Finance Committee
4. Clinical Strategy Group
5. Approvals Committee
6. Clinical Senate
NHS Wirral Clinical Commissioning Group
Audit Committee
Terms of Reference

1. Introduction

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

2. Membership

Voting Members (*)
Lay Member responsible for Governance and Audit (Chair)
Lay Member Patient Champion
3 Lay Audit Members (these will be recruited specifically to sit on the committee)

Attendees
Chief Financial Officer
Mersey Internal Audit Agency Manager/Client Lead
External Audit Manager
Director of Corporate Affairs
Local Counter Fraud Specialist
Minute Taker

3. Attendance

The Chief Finance Officer and appropriate Internal and External Audit representatives shall normally attend meetings. At least once a year, the Committee should meet privately with the External and Internal Auditors.

Other Governing Body members and other senior CCG managers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that member/senior manager.

The Accountable Officer will be invited to attend and discuss at least annually with the Committee the process for assurance that supports the Statement on Internal Control. He or she will attend when the committee considers the draft internal audit plan and the annual accounts and may be invited at other times.

The Clinical Commissioning Group Chair will be invited to attend one meeting each year in order to form a view on, and understanding of, the committee’s operations.
Representatives from NHS Protect may be invited to attend meetings, and will normally attend at least one meeting each year.

4. Secretary
The Director of Corporate will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and committee members.

5. Quorum
A quorum will be 4 members and must include at least two Lay Members and a management officer of the CCG.

6. Frequency and notice of meetings
The Committee will meet a minimum of four times a year. The external auditors or any member of the committee may request a meeting if they consider that one is necessary.

Agendas and papers will be sent out 7 days before the meeting is held. Action points will be sent out within 48 hours of the meeting occurring. Full minutes will be available within 2 weeks of the meeting.

Voting Members will also have the authority to meet with both internal and external auditors prior to committee meetings to discuss appropriate matters.

7. Remit and responsibilities of the Committee
The Group will provide assurances to the CCG Governing Body on matters of:

**Integrated Governance, Risk Management and Internal Control**
- review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the CCGs activities
- support and promote the development of the Governing Body Assurance Framework and underpinning risk management arrangements

In particular, the group will review the adequacy and effectiveness of:
- all risk and control related disclosure statements (the Annual Governance Statement) together with any appropriate independent assurances prior to endorsement by the CCG Governing Body
- all of the CCGs processes of corporate governance to enable the organisation to implement best practice as set out in appropriate guidance, this will include the Assurance Framework and the underlying risk management processes and internal controls
- an oversight on all matters relating to both Information and Clinical Governance, including the quality aspect of clinical commissioning.
- ensure the processes for transferring responsibilities from the Primary Care Trust to the new organisational arrangements are adequately managed and controlled to minimise disruption to the services provided
• the oversight arrangements for authorisation of the CCG
• the key policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, essential standards and related reporting and self-certification
• systems and processes which underpin risk management, incidents and near misses, Complaints and Mandatory Training
• the group will receive regular key performance indicator reports for scrutiny
• the CCG’s key corporate governance documents including the Constitution, Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation

The group may also request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

Financial Reporting
The group shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the Clinical Commissioning Group’s financial performance.

Internal Audit
The group shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the CCG.

This will be achieved by:

• Governance and Audit Committee Meeting
• consideration of the provision of the internal audit service, the costs associated and any questions of resignation and dismissal
• ensure that the internal audit function is adequately resourced, reflects a risk-based approach to audit, and has appropriate standing within the CCG
• review and recommend for approval, the internal audit programme (and any major changes to the plan), consider the major findings of internal audit investigations (and management’s response) and ensure co-ordination between internal and external auditors
• an annual review of the effectiveness of internal audit

External Audit
The Audit Committee will agree with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan, also ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
The group will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- review of all external audit reports, including the external auditor's report under ISA 260 “Reporting to those charged with Governance”, and if necessary provide an appropriate written response before submission to the CCG Governing Body
- consideration of the performance of the external auditors, as far as the rules governing the appointment permit
- the committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG

The Audit Committee shall review the annual report and annual financial statements before submission to the CCG, focusing particularly on:

- the wording in the Governance Statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparing of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- qualitative aspects of financial reporting

**Counter Fraud**

The group shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It should also agree the annual Counter Fraud Plan and Annual Report

8. **Relationship with the Governing Body**

The minutes of the Committee shall be formally recorded by the Committee Secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Board, or require executive action.

The Committee will produce an annual report on the decisions it has taken and submit for the Board’s consideration.

9. **Policy and best practice**
The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.

These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

10. Conduct of the Committee

As a member of the Audit Committee individuals represent the Governing Body and external organisations.

Committee members are expected to:

- actively participate in discussions pertaining to governance and audit ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the directorates and departments

- disseminate the minutes from this meeting and inform the meetings of issues discussed

When discharging functions delegated to it by the Governing Body the Audit Committee, and its individual members must:

- comply with the group’s principles of good governance
- operate in accordance with the group’s scheme of reservation and delegation
- comply with the group’s standing orders
- comply with the group’s arrangements for discharging its statutory duties
- where appropriate, ensure that member practices have had the opportunity to contribute to the group’s decision making process

These Terms of Reference shall be reviewed annually by the Governing Body, with recommendations made for any amendments in line with development requirements.

Date Agreed:

Review Date:
NHS Wirral Clinical Commissioning Group
Remuneration Committee

Terms of Reference

1. Introduction

The Remuneration Committee (the Committee) is established in accordance with NHS Wirral Clinical Commissioning Group’s (the CCG) Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Membership

Three Lay Members
Secondary Care Clinician
Chair of the Governing Body

The Chair of the Committee will be the Lay Member – Audit and Governance.

Only members of the Governing Body may be members of the remuneration committee – paragraph 6(4) of schedule 2 only refers to committees or sub-committees other than the audit or remuneration committees.

Only members of the Committee have the right to attend Committee meetings. However, other individuals such as the Accountable Officer, a Human Resources representative from North West Commissioning Support Unit and external advisers may be invited to attend for all or part of any meeting as and when appropriate, however they should not be in attendance for discussions about their own remuneration and terms of service.

3. Secretary

Arrangements will be made by the CCG to ensure that the committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and Group members.

4. Quorum

The quorum necessary for the transaction of business is two, one of whom must be a Lay Member.

5. Frequency and notice of meetings

The Committee will meet at least annually and whenever deemed necessary by the Governing Body following the publication of new guidance or a change in
circumstances which may affect the remuneration provision.

6. **Remit and responsibilities of the Committee**

The committee shall make recommendations (* Note) to the Governing Body on:

i) appropriate remuneration, benefits and terms of service for employees and people who provide services to the group, including the Accountable Officer, Chief Financial Officer, and any other staff not covered by *Agenda for Change* terms and conditions

ii) all aspects of remuneration including basic salary, performance bonus scheme, recruitment and retention, additional payments and development pay for the Accountable Officer, Chief Financial Officer and other senior staff not covered by *Agenda for Change* terms and conditions

iii) an appropriate appraisal system for the Accountable Officer, Chief Finance Officer and other senior staff who are not employed on *Agenda for Change* terms and conditions

iv) having taken into account relevant factors, the level of annual reward for the Accountable Officer, Chief Financial Officer and any other senior staff who are not employed on *Agenda for Change* terms and conditions.

v) the severance payments of the Accountable Officer and of other senior staff, seeking HM Treasury approval as appropriate in accordance with national guidance

vi) allowances under any pension scheme that the group might establish as an alternative to the NHS pension scheme

vii) where the Group has discretion, recommend other benefits which may form part of a total reward system

viii) re-location allowances above the Group's policy limit

ix) Arrangements for discharging the Group's duties as an employer.

x) human resources policies for employees and people who provide services to of the Group

**Note** * When the remuneration and other matters relating to the Chair are under discussion, the Chair must declare and interest and take no part in the meeting.

7. **Relationship with the Governing Body**

The minutes of the Committee shall be formally recorded by the Committee Secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Board, or require executive action.

The Committee will produce an annual report on the decisions it has taken and submit for the Board’s consideration.

8. **Policy and best practice**
The Committee will:

- comply with current disclosure requirements for remuneration;
- seek independent advice about remuneration for individuals when necessary
- ensure that decisions are based on clear and transparent criteria

The Committee has full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

9. **Conduct of the Committee**

When discharging functions delegated to it by the Governing Body the committee and its individual members must:

- comply with the Group’s principles of good governance
- operate in accordance with the Group’s scheme of reservation and delegation
- comply with the Group’s standing orders
- comply with the Group’s arrangements for discharging its statutory duties
- where appropriate, ensure that member practices have had the opportunity to contribute to the Group’s decision making process

Date Agreed

Date of Review
Quality, Performance and Finance Committee
Terms of Reference

1. Constitution
The Governing body hereby resolves to establish the Quality, Performance and Finance (QPF) Committee as a recognised subcommittee of NHS Wirral Clinical Commissioning Group (CCG).

The Governing Body resolves that, in the period between formal Board meetings, the QPF Committee can exercise the functions of the Governing Body on a delegated basis. Any decisions made on this basis will be reported to the next Governing Body meeting.

2. Membership
The committee shall be appointed by the clinical commissioning group's Governing Body, membership to include:

- Chair of the Governing Body
- Accountable Officer
- Chief Financial Officer
- Director of Quality & Patient Safety
- Director of Commissioning & Planning
- Director of Corporate Affairs
- Lay Member – Patient Champion
- Lay Member – Audit & Governance
- Lay Member – Quality and Outcomes
- 2 GP Executive Leads from Governing Body

The QPF meeting will be chaired by the Chair of the Governing Body. In the absence of the Chair, the meeting will be chaired by the Deputy Chair. Deputies may be sent who have been fully briefed and who have delegated responsibilities for decision making.

3. Attendance
The following key posts are also co-opted to attend in a non-voting capacity:

- Representative from Business Intelligence Team
- Head of HR (from North West Commissioning Support Unit)
- Other individuals as appropriate

Secretarial support will be provided to the committee and for supporting the chair in the management of business.

4. Relationship to the Governing Body
The Quality, Performance and Finance Committee is a subcommittee of the Governing Body. The minutes of the Committee shall be formally recorded by the Committee Secretary and submitted to the Governing Body for information and oversight.

The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the Governing Body, or require executive action.

Reports will be received from and relating to:

- Financial and Activity Information
- Performance against Targets / Objectives
- Contract Monitoring meetings
- Patient experience
- Workforce matters relating to sickness/ turnover / disciplinary

5. Quoracy
In order for the committee to be quorate, the following members will be present:

- Chair or Accountable Officer
- Director of Quality & Patient Safety
- Chief Financial Officer
- One Lay Member
- One GP Executive Lead

6. Frequency and notice of meetings

- The meetings will be held monthly, there will be no less than 8 meetings per year.
- Agendas and papers will be sent out 7 days before the meeting is held (some information may exceptionally need to be tabled on the date of the meeting for purposes of ensuring that the committee receives the most up to date information for the purposes of decision making)
- Action points will be sent out within 48 hours of the meeting occurring.
- Full minutes will be available within 2 weeks of the meeting.

In the event of an additional meeting being required outside of this, an extraordinary meeting may be called with 5 days minimum notice.

7. Duties
The remit and responsibilities of the Committee will be to:

Finance, contract monitoring & Performance

- Receive assurance that the CCG meets all its relevant obligations with regards to the quality of commissioned services including patient experience and infection control.
- Review the CCG annual finance plan for incorporation with the operational plan and recommend to the Governing Body for Approval
• Oversee and review the performance of all contracts and service level agreements commissioned by the CCG in all aspects of quality, activity, waiting times and financial performance.

• Receive regular performance monitoring reports outlining the CCGs performance against
  
  • Financial plans and budgets
  • Activity and work force plans
  • Activity performance of providers
  • Any other areas where the CCG is required to report performance to NHS England and their Local Area Team
  • Quality & Patient Experience

• Receive reports and consider assurance required for action plans which are relevant to integrated governance issues from external agencies including Care Quality Commission, internal / external audit recommendations, patient surveys / complaints etc.

• Review the outcomes and action plans associated with all serious untoward incidents to ensure that learning is shared across the CCG and its commissioned services.

• Review all exception reports relating to the quality of the patient experience including Freedom of Information requests, complaints, patient survey results ensuring that action is taken to address significant lapses.

• Review by exception any gaps in the information governance toolkit compliance and assurance that action is taken.

• Consider the assurance that the relevant standards in relation to safeguarding children and adults are being complied with and that the risks associated with those are identified and controlled.

Corporate Affairs

• Undertake the oversight of development and update approval of CCG policies, reporting for information only to the Governing Body

• Receive regular reports on areas of risk via the risk management process (risk register) reviewing and agreeing the assessment of risk scoring

• Agree and review the assurance framework and risk scoring mechanism, recommending amendments and update to the Governing Body,

• Agree the annual QIPP plan programme for the CCG, recommending to Governing Body and monitor on regular basis including risk of delivery
• Receive assurance that relevant standards are in place relating to equality and human rights.

8. Policy and best practice
The committee will apply best practice in the decision making processes, and has delegated authority from the Governing Body to commission any reports surveys it deems necessary to help fulfil its obligations.

9. Conduct of the committee.
The committee will conduct its business in accordance with national guidance and codes of conduct / good governance including Nolan’s seven principles of public life (appendix 1).

These Terms of Reference shall be reviewed annually by the Governing Body, with recommendations made for any amendments in line with development requirements.

Date Agreed:

Date of Review:
1. Introduction
An essential feature of the reforms introduced by the Health and Social Care Act (2012) is that Clinical Commissioning Groups should be able to commission a range of community based services to improve quality and outcome for patients. Clinical Commissioning Groups can also make payments to GP practices for “promoting improvements in the quality of primary medical care (e.g. reviewing referral and prescribing)” (Appendix 1).

To help them manage potential conflicts of interest associated with such commissioning decisions, NHS England issued guidance, a Code of Conduct and an associated decision making template. These documents were designed to help Clinical Commissioning Groups demonstrate that they are acting fairly and transparently and that members will always put their duty to patients before any personal financial interest.

The Governing Body of NHS Wirral Clinical Commissioning Group (the CCG) anticipated that situations will arise where a conflict of interest may exist for these members when considering commissioning decisions by the CCG. In such cases where all or most of the GPs on a decision making body could have a material interest in a decision, there is specific advice in the above mentioned Code of Conduct. In essence the advice is to ensure that GPs and other practice members who may have a potential conflict are excluded from the decision making process. In following this advice an additional mechanism to support the Governing Body in making these commissioning decisions was agreed through its Conflict of Interest Policy that this additional mechanism should be an Approvals Committee.

The Approvals Committee (the Committee) is established in accordance with the CCG’s Constitution, Standing Orders, Scheme of Delegation and Conflicts of Interest policy. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution and Standing Orders. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Purpose
The purpose and role of the Committee is to scrutinise and approve with or without conditions and/or reject commissioning decisions where a potential conflict of interest has been identified for the GP membership of the CCG Governing Body. This will help the CCG to ensure and demonstrate to its stakeholders that all of its commissioning decisions are made selflessly, fairly, transparently and with independent scrutiny.

3. Membership
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>4.</td>
<td>Lay Member – Audit and Governance (Chair) - voting</td>
</tr>
<tr>
<td>5.</td>
<td>Lay Member – Patient Champion - voting</td>
</tr>
<tr>
<td>6.</td>
<td>Lay Member – Quality and Outcomes - voting</td>
</tr>
<tr>
<td>7.</td>
<td>Lay Member (Audit Committee Lay Member) - voting</td>
</tr>
<tr>
<td>8.</td>
<td>Lay Member (Audit Committee Lay Member) - voting</td>
</tr>
<tr>
<td>9.</td>
<td>Director of Quality &amp; Performance - voting</td>
</tr>
<tr>
<td>10.</td>
<td>Director of Public Health - voting</td>
</tr>
<tr>
<td>11.</td>
<td>Chief Financial Officer - non voting</td>
</tr>
</tbody>
</table>

Should it be required the Chair of the meeting will have a casting vote.

The meetings will be chaired by the Lay Member – Audit and Governance in the absence of whom the meeting will be chaired by the Lay Member – Patient Champion.

Attendance (in a non-voting capacity) will also be expected from the following key posts within the Governing Body.

- The Chair and/or Accountable Officer may attend to advise where appropriate.
- Any Governing Body member who is not a member of the Committee may attend as a non-voting observer with the prior agreement of the Chair of the Committee.
- Experts as and when required e.g. contracting and procurement

12. Secretary

The Director of Corporate Affairs will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chairman and committee members.

13. Quorum

A quorum will be three voting members (including at least two of the Lay Members).

14. Frequency and notice of meetings

The Committee will meet when required to consider proposals coming from the Governing Body after the Governing Body Chair has deemed that commissioning decisions are unable to be reached in the Governing Body due to potential conflicts of interests for members of those bodies. The Approvals Committee is authorised by the CCG Governing Body exceptionally to call in for review and scrutiny, commissioning decisions made by the Governing Body when they believe there may be a potential for unresolved conflicts of interest in the commissioning process.

Agendas and papers will be sent out 7 days before the meeting is held. Action points will be sent out within 48 hours of the meeting occurring. Full minutes will be available within 2 weeks of the meeting.

To ensure there is minimum delay within the process, a monthly schedule of meetings of the Committee will be arranged over a 12 month schedule. If no proposals are received within 7 days of the scheduled meeting date, that meeting will not take place.
15. Remit and responsibilities of the Committee
The Committee will review and reach an agreement on all matters relating to the commissioning of health services in circumstances where the Governing Body cannot do so without independent scrutiny due to potential conflicts of interest. The Committee may approve with or without further conditions, reject or refer back to the originating body for further development, any proposal reviewed and not approved.

16. Relationship with the Governing Body
The minutes of the Committee shall be formally recorded by the Committee Secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Board, or require executive action. The Committee will produce an annual report on the decisions it has taken and submit for the Board’s consideration.

17. Policy and best practice
In order to facilitate the achievement of good governance, the Committee is authorised to:

- Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- Use an amended version of NHS England Conflicts of Interest Template when gathering information about commissioning proposals to help support its decision making.
- Obtain outside legal or other independent professional advice and/or secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- Use core national criteria when assessing clinical decisions and ensure that commissioning proposals support the strategic intentions of the CCG

18. Conduct of the Group
When discharging functions delegated to it by the Governing Body the Approvals Committee, and its individual members must:

- Conduct its business in accordance with Nolan’s Seven Principles of Public Life.
- Ensure that any relevant national guidance is adhered to.

These Terms of Reference shall be reviewed annually by the Governing Body, with recommendations made for any amendments in line with development requirements.

Date Agreed:

NHS Wirral Clinical Commissioning Group’s Constitution
Version: 1.6
Date of Review:
NHS Wirral Clinical Commissioning Group
Clinical Senate

Terms of Reference

Introduction and Purpose

This will provide a forum where collective knowledge, advice and recommendation can be provided to the Governing Body. The Clinical Senate will provide the mechanism for increasing clinical participation across the professional groups in primary care and offer the opportunity for the expression of a unified clinical perspective on important commissioning and delivery issues.

Building upon the CCG track record of General Practitioner leadership within divisions, the broadening of clinician representation in the Clinical Senate will provide the opportunity for clinicians to establish a multidisciplinary group in influence and leadership in driving forward service transformation. The Clinical Senate will ensure that improved health outcomes for the population of the Wirral are underpinned by a focus on quality and safety.

In developing a truly integrated approach to the provision of health care, the Clinical Senate will contribute to the delivery of our strategic and operational plans whilst providing clinical ownership of the objectives of the CCG. The Clinical Senate will provide a clinical perspective on provider and primary care performance, guiding how issues could be remedied whilst ensuring any improvement requirement are from within a perspective of maintaining quality and safety.

The further role and remit of the Clinical Senate is to get clinician engagement and feedback on a wider level, it is therefore proposed that there is a process whereby a larger formal arrangement is in place biannually with all the professional groups, to influence next year commissioning priorities and midyear performance review. It is not designed to reflect the numbers of staff within each of the professional groups.

Membership

Membership of the Clinical Senate is as below.

- Medical Director
- Secondary Care Doctor
- Director of Quality and Patient Safety
- Four GP Executive Leads
- Other GPs co-opted with particular interest and expertise as appropriate to the work plan
- Nursing Representative
- Two Therapist representatives (must be different professional groups)
- Local Medical Committee representative
- Pharmacist/medicines management representative
- 3 Provider representatives (Mental Health, Community, Acute)
- Public Health Representative

Role and Remit

The functions of the Clinical Senate are to:

**Inform Commissioning Reform** in the areas of:
- Major clinical strategic areas including clinical service planning and reform, models of care and service delivery
- Strategies to improve patient care by improving the integration of services to patients across all settings of care
- Identifying relevant innovations, emergent best practice and research findings in healthcare to inform future strategies
- Strategies to support the transformation of health and social care services to reduce the growth in hospital demand

**Influence Clinical Excellence** in the areas of:
- Strategies to implement clinical guidelines and standards
- Strategies to improve the safety quality, efficiency and sustainability of clinical services and prevention strategies
- Strategies to improve the professional links between partners organisations and professional groups

**Recommend**
- Discuss and make recommendations on key clinical issues as determined by the Governing Body

**Engage**
- Provide a forum for multidisciplinary discussion of redesign and clinical developments
- Improve engagement of clinicians in influencing the future commissioning intentions and delivery
- Provide further opportunity for the provision of assurance that new models care / pathways will have positive impact on patient safety and experience
Quorum

- A quorum for meetings will be chair or vice chair presence and
- At least two other members

Decision Making

The clinical senate will be expected to reach decisions as a consensus where possible, it should be remembered this is an advisory not decision making body.

Frequency of Meetings

Bi- Monthly

Reporting Arrangements

The Clinical Senate will report to the Governing Body

Feeder meetings

Membership Council and GP Provider Forum

Review

Annual review will take place

Date Agreed

Date of Review
Appendix 1

Constitutional Implications
Of the Capability and Governance Review

Introduction

The purpose of this report is to outline the constitutional implications arising from the Capability and Governance Review.

Summary of key issues from the review with constitutional impact

- Consortia arrangements are not discrete, mosaic in nature and not population based
- Managerial resource invested in servicing relatively autonomous functioning of consortia that has led to fragmentation
- Governing Body is constituted from representation that reflects the fragmented, mosaic consortia arrangements
- Lack of cohesive strategic approach to commissioning resulting from consortia arrangements
- Current practice engagement arrangements via consortia are ‘weak’ and hence there is a need for new approach to member engagement
- Separate arrangements not in place for engaging with practices as providers
- Complex and unclear governance arrangements for decision making resulting from consortia arrangements
- Need for urgent review of the composition of the Governing Body, including the methods of identifying GP representatives and the Chair

The proposed areas of amendment:

In addressing the fundamental problems resulting from the consortia and governance arrangements highlighted by the review, there are number of areas that require immediate change:

- Methods for determining clinical leaders
- Governing Body Composition
- Membership and clinical engagement methods
- Governance arrangements

In addition to the evidence provided from the CCG 360 degree survey, LMC survey of members and the review itself, the CCG has utilised a number of sources to inform the amendments

- Other ‘best practice’ constitutions
- NHS England advice
- Member practice engagement events
Methods of determining clinical leaders

There are advantages and disadvantages with an election and appointment process. Election is more likely to maintain the ownership of the member practices and ensure the leaders are responsive to their members. Appointments are more likely to ensure the leaders have the right skills, competencies and attributes.

Whilst there are diverse views on this issue there is overwhelming support for the development of a model that provides a balance between election and appointments based on skills, knowledge and experience.

With that in mind, it is suggested that a model is adopted that fulfils both of those requirements.

The Chair and Medical Director/Assistant Chair will be elected posts. Each role will have a defined job description and person specification outlining duties, expectations and skill-set criteria. Additionally, the Chair will be approved or accredited through any stipulated assessment process, including any required by NHS England within 3 months of taking office. The tenure for these posts will be four and three years respectively so as to provide continuity.

Those who meet the defined criteria and are also a GP (partner or salaried) on the performers’ list and working substantively in a Wirral practice, will be eligible to stand for election.

Each practice will be balloted (as members of the CCG are practices, not individuals), with a weighting based on list size (based on multiples of 2500 registered patients, where 1-2500 would be 1 vote, 2501-5000, would be 2 votes and so on).

For both roles, the candidate with the largest number of votes will be elected to the position.

The Governing Body defines a further 4 GP Clinical Lead Posts, which mirror the key work-streams of the CCG. These also reflect the Joint Strategic Needs Assessment and the Vision 2018 ‘for a healthier Wirral’ programme.

- Primary Care
- Unplanned Care
- Planned Care
- Long Term Conditions

Given the future challenges and opportunities faced by Primary Care it is suggested that the Lead Primary Care post also adopts an elected process. The CCG would work with the Local Medical Committee in ensuring all election processes are robustly conducted.
For the remaining posts in **Unplanned Care, Planned Care** and **Long Term Conditions**, as these require specific skills, interest and experience these will be selected through a process of assessment and interview against agreed job descriptions and specifications. For each of these posts, along with the Primary Care lead post, it is suggested that the have a three year tenure so as to ensure equity between the elected and appointed posts.

To ensure an open and transparent process, member involvement and probity, it is suggested that the Local Medical Committee, Lay Person and an external assessor are part of the panel assessment process.

In addition to these posts so as to provide stronger assurances it is further proposed that two additional positions are developed. An additional GP role, elected by the Membership Council and an independent Registered Nurse who would be appointed in the same way as the Secondary Care Doctor. The CCG would be supportive of involving the Local Medical Committee in the appointment of the Registered Nurse. Both roles add to the independent assurance challenges at Governing Body.

**Board Composition (Clinical)**

**Governing Body composition**

Other constitutions reviewed demonstrated a mix of approaches to Governing Body membership. Wirral Practice membership feedback favoured a strong clinical
influence and hence the balance of representation is towards clinical members, with a view that the posts identified below should all be held by GPs currently working in Wirral practices.

This is balanced by statutory requirements to have additional clinicians on Governing Body such as a Secondary Care Doctor and a Registered Nurse.

There are currently also two statutory Lay Members (one acting as a patient champion and one leading on audit and governance) and it is further proposed that an additional Lay Member is recruited to provide additional assurance. As a result the managerial posts on the Governing Body are in a voting minority. These managerial posts are reflective of the functions of the CCG.

Also in attendance at the Governing Body will be a representative from Healthwatch and a representative from the Local Medical Committee, to provide further external assurance and scrutiny.

In summary:

**Clinical (where a requirement of the post)**

- Chair (GP)
- Medical Director (GP)
- Clinical Lead Planned Care (GP)
- Clinical Lead Unplanned Care (GP)
- Clinical Lead Long Term Conditions (GP)
- Clinical Lead Primary Care (GP)
- Membership Council Representative (GP)
- Director of Quality and Patient Safety (Registered Nurse)
- Registered Nurse
- Secondary Care Doctor

**Managerial (clinicians can occupy these roles, but not a requirement of the post)**

- Accountable Officer
- Director of Commissioning
- Chief Financial Officer
- Director of Corporate Affairs

**Lay Representation**

- Audit and Governance
- Patient Champion
- Additional Lay Member

**In attendance**

- Director of Public Health
- Director of Adult Social Services
Membership and clinical engagement methods

The development of a clinical senate as new approach to wider clinical engagement

- The Clinical Senate will provide the opportunity for clinicians to establish a multidisciplinary group in influence and driving forward service transformation.
- The Clinical Senate will ensure that improved health outcomes for the population of the Wirral are underpinned by a focus on quality and safety.
- In developing a truly integrated approach to the provision of health care, the Clinical Senate will contribute to the delivery of the CCG’s strategic and operational plans whilst providing clinical ownership of the objectives of the CCG.
- The Clinical Senate will provide a clinical perspective on provider and primary care performance, guiding how issues could be remedied whilst ensuring any improvement requirement are from within a perspective of maintaining quality and safety.
- Its key duties will be to:

Inform commissioning reform in the areas of:
- Major clinical strategic areas including clinical service planning and reform, models of care and service delivery
- Strategies to improve patient care by improving the integration of services to patients across all settings of care
- Identifying relevant innovations, emergent best practice and research findings in healthcare to inform future strategies
- Strategies to support the transformation of health and social care services to reduce the growth in hospital demand

Influence clinical excellence when developing:
- Strategies to implement clinical guidelines and standards
- Strategies to improve the safety quality, efficiency and sustainability of clinical services and prevention strategies
- Strategies to improve the professional links between partners organisations and professional groups

Recommend:
- The Senate will discuss and make recommendations on key clinical issues as determined by the work plan of the group or as requested by the Governing Body
The development of a Membership Council to create a Wirral Wide practice engagement forum

Membership Council will be a forum whereby member practices can come together to discuss and inform key commissioning issues. The principles behind the Members Council meeting are:

- To work effectively with GPs, including sessional and locum GPs, to feed the practice’s views into commissioning decisions.
- To facilitate relationships with Governing Body members and member practices
- To give voice to member practices by ensuring members are engaged, informed and empowered to participate.
- To seek advice and views of practice members of Wirral CCG
- To represent their practice’s views and act on behalf of the practice
- Facilitate communication between members and the CCG Governing body
- To shape the culture of Wirral CCG
- Driving forward improvements in the services for patients, carers, communities

The development of a GP Provider Forum

This forum will be where GP practices can meet to discuss issues regarding GP practices in their roles as providers. This will be led by the GP Executive for Primary Care and would focus on issues such as implementation of enhanced services and other local schemes, Primary Care workforce issues, and other topical issues.

With the development of co-commissioning this forum is seen as a critical part of the new architecture.

Local sensitivity in commissioning

It is proposed that the 4 managerial ‘Heads’ within the CCG Commissioning structure will act as named link staff to 4 geographic MP constituencies. This will give practices a route to engage with the CCG in presenting local issues in their local communities. It is further suggested that practice managers, practice nurses and patient engagement groups will also operate on this basis so as to retain local sensitivity, share best practice and reflect variation of need.

The 4 managers will also regularly attend Neighbourhood Constituency meetings in these geographic areas to both inform commissioning, brief local residents and build partnerships with other agencies such as Police and Fire and Rescue.

From a planning perspective, the commissioning teams responsible for planning and delivery will ensure these local perspectives are taken into account when developing specifications that might require differential models that reflect and address health inequalities.

This addresses the call from members to develop local sensitivity without the need for bureaucracy and will need to develop and mature over time.
This will be an early consideration for the new GP Membership Council.

**Governance arrangements**

There are four principle roles for any governing body be it NHS or Industry.

These are Accountability, Foresight or Vision, Strategy and Management. The table below applies this to the new CCG constitution so as to provide members with a perspective of how future roles and influences will fit with the decision making process.
**Impact Assessment**

In line with the guidance from NHS England entitled “Procedures for Clinical Commissioning Group constitution change, merger or dissolution” (May 2013), the CCG will also engage with key stakeholders and patients in order to comply with the impact assessment. The CCG will also seek legal advice on the revised constitution prior to submission.

**Recommendation**

These constitutional amendments are a result of careful and considerate engagement and reflective of the urgent need for change. It is now recommended that these are incorporated into a revised constitution for consideration by the CCG Governing Body and submission to NHS England.

Jon Develing  
Interim Accountable Officer
Appendix 2

Clinical infrastructure

Management infrastructure
Appendix 2

New commissioning infrastructure

Director of Commissioning & Contracting

Head of Strategic Planning & Outcomes
- JSNA
- Commissioning Intentions
- Outcomes
- Vision / Strategic
- Commissioning Group
- Service Redesign
- 2 and 5 year operational and strategic planning

Head of Delivery & Contracts
- Performance (RTT / A&E / Cancer)
- Contract Negotiation & Management (WUTH / CT / CWP / Other)
- Programme Management
- Assurance
- Business Intelligence (Delivery)

Head of Direct Commissioning
- GP Member Community Engagement
- Patient and Public Engagement
- Primary Care Strategic Vision
- Quality in Primary Care
- Performance Management
- Future Co-Commissioning Arrangements (Primary Care)
- Future Co-Commissioning Arrangements (Specialised Commissioning)

Head of Partnerships
- Public Health
- Learning Disabilities
- Mental Health
- Children’s
- Joint Commissioning
- Local Authority (CHC, Packages of Care)
- Better Care Fund
Integrated Performance and Finance Report

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>4.1</th>
<th>Reference:</th>
<th>GB14/15/0046</th>
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</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body</td>
<td>Meeting Date:</td>
<td>11th November 2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Mark Bakewell, Lorna Quigley</td>
<td>Contributors:</td>
<td>CCG Finance and Business Intelligence teams</td>
</tr>
<tr>
<td>Governance:</td>
<td></td>
<td>Link to Commissioning Strategy</td>
<td>Sound financial control is essential to the Clinical Commissioning Group (CCG) strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plan for the financial year. Ensuring that services that the CCG commission for the population comply with patient’s rights under the NHS constitution.</td>
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<tr>
<td></td>
<td></td>
<td>Link to current governing body Objectives</td>
<td>To achieve financial control total with sound financial management. To ensure that providers achieve strong performance against national targets.</td>
</tr>
<tr>
<td>Summary:</td>
<td>This report updates the Governing Body on:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Activity &amp; Performance for 5 (August)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Financial performance against budgeted allocation for 2014/15 as at Month 6 (September)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation:</td>
<td>To Approve</td>
<td>To Note</td>
<td>✓</td>
</tr>
<tr>
<td>Next Steps:</td>
<td>Continuation of performance monitoring through the remainder of the financial year</td>
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</tbody>
</table>

This section is an assessment of the impact of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.

What are the implications for the following (please state if not applicable):

<p>| Financial | The report sets out the financial performance within the CCG for 2014/15 financial year |
| Value For Money | All expenditure plans are subject to an ongoing value for money review. |
| Risk | The report details the key risks and how these will be monitored in year as part of the reporting process |</p>
<table>
<thead>
<tr>
<th>Legal</th>
<th>Legal advice is sought on issues as and when required.</th>
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<tbody>
<tr>
<td>Workforce</td>
<td>The financial plan includes budgeted “running costs” expenditure and is reflective of the respective workforce implications in these areas</td>
</tr>
<tr>
<td>Equality &amp; Human Rights</td>
<td>Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure</td>
</tr>
<tr>
<td>Patient and Public Involvement (PPI)</td>
<td>Budgets include funding to ensure continued involvement of patients and public in CCG decisions. Patient choice is a right under the constitution in relation to referral for treatment.</td>
</tr>
<tr>
<td>Partnership Working</td>
<td>The CCG works with a number of NHS Trusts and the Local Authority on a number of its commissioning budgets.</td>
</tr>
<tr>
<td>Performance Indicators</td>
<td>The plan reflects the planned achievement of statutory financial duties and patient’s rights under the NHS constitution</td>
</tr>
</tbody>
</table>

**Do you agree that this document can be published on the website?**

(If not, please note that it may still be subject to disclosure under Freedom of Information - [Freedom of Information Exemptions](#))

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path i.e. other papers that are directly related to the current paper under discussion.

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Reference</th>
<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPF Updates</td>
<td></td>
<td>Quality, Performance and Finance Committee</td>
<td>30th September</td>
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</tr>
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</table>

**Private Business**

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this
applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.
Minute: WIRRAL HEALTH COMMISSIONING CONSORTIUM
EXECUTIVE COMMITTEE
Minutes of Meeting

Wednesday 16th July 2014
Albert Lodge - Victoria Central Health Centre

Present:  Dr Sue Wells (Chair)  Deputy Chair
Andrew Cooper    Chief Officer
Dr David Jones    GP Executive Lead
Debbie Platt    Practice Nurse Representative
Diane Moon    Practice Manager Representative
Brian Knight    Patient Forum Chair
Louise Morris    Senior Finance Accountant

In Attendance:
Grace Price – Jones    Executive Assistant

Ref No    Minute

WHCC/EB/ 14-15/001

1.1 Apologies for Absence
Apologies were noted for Barbara Dunton, Dr Sian Stokes and Dr Paula Cowan.

WHCC/EB/ 14-15/002

1.2 Declarations of Interest
There were no declarations of interest highlighted.

WHCC/EB/ 14-15/003

1.3 Public Comments/Questions
There were no members of the public in attendance at the meeting.

WHCC/EB/ 14-15/004

1.4 Minutes and Action Points of the previous meeting
The minutes of the previous meeting were agreed as a true account of the last meeting.
One amendment was requested under 1.4 the word ‘running’ to ‘supporting’.

Matters Arising
The committee discussed the difficulty with the meeting being held bi-monthly. It was agreed that monthly an informal pack will be distributed to the board containing the minutes of the previous meeting and any subcommittee minutes.

The Alcohol pathway was highlighted as it has not yet been sent out the practices. The Executive Assistant agreed to follow this up.
Ref No | Minute
--- | ---

**Action:** follow up the Alcohol pathway being distributed to practices.

It was raised that EMIS have informed practices that they will no longer be providing a text messaging service.

**Action Points**

All action points were completed.

---

**2.1 Intermediate Diabetes Service**

The committee were given the history of the scheme. The nurse providing the service has resigned from the role. The contract sits within Wirral University Teaching Hospital (WUTH) and the role will be advertised for appointment. The GP with Special Interest (GPSwI) has informed WHCC that the service can continue without Nurse Support for the moment however, it may be possible to provide Practice Nurse support on a temporary basis.

This service also offered a mentoring scheme within practices. This unfortunately has been withdrawn but an alternative of case based discussions will be provided.

There was a query as to whether practices were to receive backfill payments for the mentoring.

**Action:** enquire as to whether practices were to receive a backfill payment for mentoring sessions.

---

**2.2 Service Review Updates**

The committee reviewed the following service evaluations updates to consider for the next financial year:

1. Iplato
2. Telehealth
3. Falls Pick up service
4. High Quality Referrals
5. STarT back pain tool

Iplato Text Messaging Service – the history was explained to the committee. The paper has returned back to the committee due to the cost negotiations being reduced to £12k from £37k since it was last submitted to the committee. Further to that it became clear that the other two divisions are continuing to support this service for their practices. An email discussion was held between all board members and a unanimous decision made that for equity of service we should continue to support for the time being. There was a discussion about the discontinuing of EMIS Clinical System no longer providing the service. Iplato are currently working with the Health and Social Care Information Centre (HSCIC) to discuss the use Nationally. The Operations Manager has also been assured that the division will not have a duplicate payment if the text messaging is rolled out Nationally within the year.

Telehealth – Ten patients within WHCC are currently using the service. The service has been committed to for another year. There was a discussion about the small number of
<table>
<thead>
<tr>
<th>Ref No</th>
<th>Minute</th>
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<tr>
<td></td>
<td>referrals being made and the rationale for this. There was a discussion as to whether practices implementing the Unplanned Admission DES may consider patients suitable for Telehealth. There has been a discussion with the Alternative 2 Hospital (A2H) Service but they are yet to identify any suitable patients. It was also queried whether the hospital would be able to identify any patients.</td>
</tr>
<tr>
<td></td>
<td><strong>Action:</strong> Highlight to the hospital patients that could be referred into the Telehealth Service.</td>
</tr>
<tr>
<td></td>
<td>Falls – This service has now been rolled out to all divisions within Wirral CCG. The data shows that the service has picked up 160 WHCC patients only calling ten ambulances. The funding for this service is now part of the Better Care Fund. WHCC Executive Committee would recommend this scheme.</td>
</tr>
<tr>
<td></td>
<td>High Quality Referrals Scheme – the committee reviewed the paper. Unfortunately the referrals have increased since the scheme was commissioned. The committee felt that further evaluation needs to be made against the plan and also against last year’s activity by the other two divisions. There is a possibility that this scheme would have improved the quality of referrals. The board felt that it would be interesting to know whether practices have continued to discuss referrals now the scheme has come to an end. Dermatology referrals were highlighted due to an increase even with the current Dermatology Upskilling service.</td>
</tr>
<tr>
<td></td>
<td>It was agreed that if this scheme fits within the plan this is a positive message to practices. Practices will be congratulated for their efforts following obtaining further information regarding referrals.</td>
</tr>
<tr>
<td></td>
<td><strong>Action:</strong> add to the practice visit agenda and query whether practices have continued to meet and discuss referrals. <strong>Action:</strong> Practices to be congratulated on all of the work involved in the referral meetings.</td>
</tr>
<tr>
<td></td>
<td>STarT back pain tool – the evaluation was reviewed by the committee. There was mixed reviews across the different practices. If practice wish to continue to use the tool, practices will need to obtain the patients booklets themselves. Practices can resource these booklets from Arthritis UK.</td>
</tr>
</tbody>
</table>

### 3.1 Finance Update

The Finance Lead presented the Finance Report. The total budget available to WHCC is £187m. This is an increase of 0.90% since last year. There is currently no divisional data available.

### 3.2 Items for Risk Log

No items were identified for the risk log.

### 3.3 Risk Register

The committee reviewed the risk register. The risk register requires updating for this financial year.
### Action: Risk Register to be updated.

#### 4.1 Subgroup Minutes for Noting

The minutes from the subcommittees were noted by the Board.

It was noted that there was no clinician available to attend the Business Development Committee in May.

The Operations Manager is still waiting on some practices to return their practice protocols. These will then be uploaded onto the WHCC website to share for other practices to utilise.

The board discussed low attendance of representatives at the Patient Forum.

#### 5. Summary of Actions

Please refer to action points attached.


The summary was noted by the committee.

#### 7. Any Other Business

Concerns were raised in regards to the Phlebotomy Service and the centralised booking service. Some of the issues taking place within practices were highlighted and the board was assured that these are being addressed with the provider. The CCG has taken some responsibility in regards to the practice knowledge of the specification. There has been a six month grace period for practices to transfer onto the central booking system. There has been a mention of some practices wishing to opt out of the service which could threaten the procurement process. The Operations Manager is currently working with both the provider and the GP practices to ensure that the implementation of the service is smooth running.

Puffell has approached one of our member practices to attend one of the practice meetings and discuss a potential pilot. This will be fed back at the next meeting.

The decision has been made to suspend the practice visits throughout the summer. It is felt that due to the current situation within the CCG the visits may not be deemed very beneficial at this point in time.

It was raised that there have been a small number of occasions that the A2H service have admitted patients into Nursing homes that are not involved in the service meaning that there is an issue regarding payment. Sarah Quinn, Programme Manager is working with the service to ensure that this does not happen again in the future.
<table>
<thead>
<tr>
<th>Ref No</th>
<th>Minute</th>
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<tbody>
<tr>
<td></td>
<td>The date and time of the next meeting is Wednesday 17\textsuperscript{th} September 2014, 1.00pm at Albert Lodge, Victoria Central Health Centre.</td>
</tr>
<tr>
<td></td>
<td>Please send any further apologies to Grace Price-Jones on <a href="mailto:g.price-jones@nhs.net">g.price-jones@nhs.net</a></td>
</tr>
</tbody>
</table>
Notes & Actions of Meeting

Tuesday 30th September 2014
1pm Room 539, 5th Floor, Old Market House

Present:
Pete Naylor (PN)  Interim Chair
Iain Stewart (IS)  Chief Officer WACC
Lorna Quigley (LQ)  Head of Quality and Performance
James Kay (JK)  Lay Member (Audit & Governance) WCCG
Simon Wagener (SW)  Lay Member (Patient Champion)
Laura Wentworth (LW)  Corporate Support Officer
Mark Green (MG)  Chair WACC
Mark Bakewell (MB)  Chief Financial Officer
John Oates (JO)  Chair WGPCC
Sue Smith (SS)  Lead Nurse for Quality & Patient Safety

Guest Speakers:

Minute Taker/Support: Chelsea Worthington (CW)  Corporate Support Admin

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
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<tbody>
<tr>
<td>QPF 14-15/0026</td>
<td><strong>1.0 Standing Agenda Items</strong></td>
</tr>
<tr>
<td></td>
<td><strong>1.1 Apologies for absence</strong></td>
</tr>
<tr>
<td></td>
<td>Apologies were received from: Christine Campbell, Andrew Cooper and Jon Develing</td>
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<tr>
<td></td>
<td><strong>1.2 Declarations of Interest</strong></td>
</tr>
<tr>
<td></td>
<td>Dr PN declared his interests regarding Ophthalmology and Minor Surgery.</td>
</tr>
<tr>
<td></td>
<td><strong>1.3 Minutes of Previous meeting from 26th August 2014</strong></td>
</tr>
<tr>
<td></td>
<td>The minutes from the previous meeting held on 26th August were agreed as true and accurate record, notwithstanding typographical and grammatical errors.</td>
</tr>
<tr>
<td></td>
<td>There were no matters arising</td>
</tr>
<tr>
<td>QPF 14-15/0027</td>
<td><strong>2.0 Items for approval</strong></td>
</tr>
<tr>
<td></td>
<td><strong>2.1 No items for approval</strong></td>
</tr>
<tr>
<td>QPF14-15/0028</td>
<td><strong>3.0 Items for Discussions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>3.1 Performance Reports</strong></td>
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<tr>
<td></td>
<td>LQ presented the performance report to the group for July 2014.</td>
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<td></td>
<td>The committee was asked to note:</td>
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<tr>
<td></td>
<td>Referral to treatment target (RTT)</td>
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<td></td>
<td>Due to national drive to clear the backlog of patients waiting more than 18 weeks for</td>
</tr>
</tbody>
</table>
Admitted breaches in:
  • Urology (80%)
  • General Surgery (88.79%)
  • Gynaecology (85.8%)
Non Admitted breaches in:
  • Urology (88.1%)
  • General Surgery (88.6%)
Incomplete breaches in General Surgery 89.2% and Neurology 75%

It was highlighted that pressures remain at Alder Hey and the performance issues are being managed by the Area Team.

JK queried regarding the monthly infliction with 26+ weeks
LQ advised that if you are not treated within 6 weeks this will then breach the 18 week target for treatment.

Excessive Waiters
There is 1 patient waiting 52+ weeks in the London University Teaching Hospital. The Area Team is supporting the CCG to trace if this patient has now received treatment.

LQ suggested that this report could be made more pictorial with a definition, to send out to the group for a clearer explanation.

MB explained that there may not be assurance in August/September's meeting as there is currently the process of dropping to 16 weeks. Hopefully figures should start to reflect from October.

LQ explained that we are looking for the reassurance of what is showing both locally and nationally.
To add note to November/December's meeting to approve the hypothesis.

A & E waiting times (this is monitored quarterly)
A & E at Wirral University Teaching Hospital (WUTH) fell short of the target in July however; Walk In Centre (WIC) performance has met the target for this reporting period.
Combined A & E and WIC have not met the operational threshold. WUTH have been identified as one of the 30 worse performing hospitals in relation to the 4 hour target. A weekly performance management framework has been implemented to ensure delivery against this standard going forward.

JK advised that NHS choices have recently brought out a new tool with regards to waiting times which appears to be displaying incorrect information. JK explained that he has sent email to explain to NHS Choices to advise of this which has been copied to JD.

LQ explained that there is currently a struggle with Ambulance times. Arrival time targets were under target at 68.1% in July and handover performance was under regional performance at 90.2%

LQ advised that cancer waiting times are measured quarterly. Although currently in red with 81.7% we have hit target for Quarter 1.

SW mentioned that reducing healthcare acquired infections overall should at least be amber.
LQ agreed to amend this on the report.
<table>
<thead>
<tr>
<th>Ref No.</th>
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<tr>
<td>LQ reported that there was 1 current case of MRSA which is waiting analysis.</td>
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<tr>
<td>LQ advised that there was a positive response from the friends and family test for July</td>
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### 3.2 Finance Reports & WUTH Report

MB presented the finance report for month 5 (August) in the 2014/15 financial year. The group noted that the report sets out the financial position for NHS Wirral CCG at the end of August within the current financial year and performance against the measures outlined in the CCG Assurance Framework for 2014/15.

MB explained that the CCG will be declaring to the Area Team that we are currently not hitting target and MB has arranged a meeting with Debbie Hayman the Interim Director of Finance at NHS England Area Team, to discuss this further. It was noted that we currently have an overall underspend with WUTH of £1.7 million.

MB explained that there is an error on the table in the booklet with regards to figures. Committee noted to focus on the table sent out to staff prior to meeting, separate from the papers.

It was noted that the bed day count at Wirral is down, but up at other trusts connecting that with the trauma network.

The largest underspend against plan is WUTH, currently at £1.958m. Royal Liverpool Broadgreen continues to over perform, now £418k at the end of August. An increase of £188k from previous month. Critical Care remains a high area of spend as does non elective spend.

Non NHS contracts show an under performance at the end of month of £142k, compared to £258k under plan as at Month 4. Spa Medica’s over performance is now at £56k with £20k in July alone. The pressures relate to charges for YAG laser procedures carried out by Spa Medica and charged on an NCA basis. Spa are performing the procedure as we are responsible for clinical contractual for that. LQ explained that is cataract surgery is done early this can then lead to YAG laser.

JO explained that the referrals to spa would have gone through optometrist, and suggested that it would be advisable to check with them regarding this.

It was noted that three months prescribing data (April –June) has been received. Performance is currently £161k over plan. This is 200K over against practice prescribing and 38k underspend against federated budgets.

MB advised that he is having a meeting with the CSU Medicines Management Lead on the 1st October to look at these issues and to focus on the areas over the financial year. MB advised that we will continue to monitor this.

MB highlighted that Commissioned out of hospital is an area of concern. There is currently an action plan with the CSU around the key issues. As at the end of September, joint/fully funded and children’s packages are overspent by £677k, this is an adverse movement of 180k on the previous month. There has been a number increased package costs agreed in month and number of new packages agreed.

The CCG is currently finalising its QIPP plan, this identifies and agrees relevant action plans for the delivery of the QIPP agenda which includes both financial and non-financial
<table>
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|         | performance improvement areas. Updates with be received by QPF and GB. As at month 5 we have seen an improvement. The current figure is 6.3 where as previously it was 6.9. MB advised that month 5 has been sent to the committee to show the improvement although there are still gaps. MB explained that there are 2 current issues with the financial risks. 1 CHC Restitution claims, MB explained that we will get more amounts in further years and DOLS there are no further assumptions. It was noted that the CCG balance sheet for Q1 has been included for nothing this month. MB advised that he will bring the balance sheet quarterly to meetings. **Action- MB to create a crib sheet and present a short update at the January meeting to explain further** MB explained that we currently have a challenge to hit target with WUTH and CHC being the main current issues. MB advised that he will bring the financial plan to the meeting next month for the next year which will show things moving forward. MG queried the progress of the CHC review. IS explained that MIAA have undertaken an initial assessment and the next stage is to review their findings and consider the next stage. It was noted that MIAA are due to provide suggested outcomes by the end of October. IS explained that himself and LD have spoken to the CSU with regards to the delays in responses, decision making and responses being provided to patients in relation to CHC. The group were asked to note this risk and that a paper with further detail is being presented to the next Governing Body meeting to be held on 7th October. The committee noted that they received the report outlining the issues from IS. IS also highlighted that it has been found that the CHC Team have not been undertaking annual reviews with the current packages of care which are in place. SW noted that we could save money if care packages were to go down but could also be in an opposite position if prices go up. The committee is asked to note: • The CCG financial position as at end of August 2014 • Performance against indicators based on the information available • The associated financial risks within the declared position including the impact of potential resource allocation issues, including the relative adverse movement between months. **3.3 Stroke SSNAP report** LQ presented the Stroke SSNAP report paper to the committee. The paper describes the performance of Wirral stroke services against quality indicators for Q4 of 2013-14 measured by the Sentinel Stroke National Audit Programme (SSNAP) It was noted that WUTH are performing above national average on the majority of the indicators. However, there are a number of exceptions which are included within the report.
Our potential years of life loss due to stroke is currently below the national and Cheshire Warrington and Wirral area team average.

LQ explained that Wirral Hospital is now classed as a hyper acute stroke unit.

69% of people who have a stroke are aged 70 and over
12% of them are over the age of 90

LQ explained that the Q1 SSNAP report highlighted a significant number of Wirral patients having a stroke who had either previously had a stroke or who had AF prior to the stroke.

LQ presented WUTHs achievement against the 10 domains compared to the national average.

Attention was brought to domain 1 the national average for median time to scan is 1 hour 18 mins whereas WUTHs is currently at 1 hour 28 mins.
Also under domain 3 the proportion of patient’s thrombolysed within an hour is 56% nationally and WUTH are currently at 28%. The median time between clock start and thrombolysis is nationally at 56 minutes and WUTH are at 1 hour and 16 minutes.

Attention is also brought to under domain 10 the proportion of patients with joint health and social care plans, the national average is 75% and WUTH are currently at 47%. This needs further work on as they are really falling behind.

JO queried if thrombolysis takes place in A and E and if so could this be down to A and E waiting times?

PN, SW & JK thanked LQ for a very useful paper.

LQ explained that Mortality rates are reviewed annually rather than quarterly. The quarterly report estimates that 32 patients died in hospital following their stroke. This equates to 17%, the national average is 16%. The data does not take into account age, stroke severity, haemorrhage or AF.

Post Discharge Care when the patient is discharged home is currently at 52 patients which the percentage is 42%. This runs the risk of sending them home without a care plan and that readmission figures could go up.

WUTH provide a 7 day ESD service and are in discussions with Countess of Chester about collaboration to provide further weekend coverage across the patch. ESD performance data is not currently available on SSNAP however there are plans to introduce in the future.

The next steps are to:
- Continue to monitor SSNAP data quarterly and report to QPF 6 monthly
- Continue to promote importance of anticoagulation for AF patients with GPs
- Work with Public Health to agree a joint approach to stroke prevention, management and evaluation. This links to some of the experience learned commissioning work underway

4.0 Items for Information and Noting

4.1 Contracting Issues
### 4.2 Complaints update

LW presented the update report on the complaints (including those escalated to the Parliamentary and Health Service Ombudsman) and MP enquiries received by the CCG as at the 16th September.

There were:
- 4 new complaints
- 1 complaint whereby extra action is required
- 2 complaints closed
- 3 on-going with 1 case with a missed date but the letter has now gone out.

There continues to be a number of complaints relating to continuing health care being received and issues with the process, timelines and quality and response letters has been escalated to the Director of the service line at CSU and an action plan is in place to address the issues.

MP Letters:
- 2 new received
- 3 closed
- 1 on going

No trends have been found in relation to MP letters during this reporting period.

There are currently no complaints that have been escalated to the Ombudsman.

SW asked for further information on the re-opened complaint ID963 of which LW provided.

### 4.3 FOI Update

LW presented the FOI report that details the requests received and closed during the reporting period of August 2014.

There have been 28 requests which shows an increase from the previous month. The average response is 13 days and 20 FOI's have been closed. All FOI queries and responses are now published on the CCG’s public facing website, as per the publication scheme. The responses are updated on a monthly basis.

It was also noted that FOI requests will be managed by the CCG from 1st October 2014, and will no longer be processed by the CSU.

### 4.4 Serious Incidents

The Quality, Performance & Finance Committee were asked to note the 9 new serious incidents reported to the SteIS in August 2014, relating to:

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
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<tbody>
<tr>
<td>CWP – No current issues were noted.</td>
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<tr>
<td>CT - there are no current issues. MG advised that he had recently had a meeting with 111. We need to get moving on the out of hour’s contract, update to go to next weeks ops.</td>
<td></td>
</tr>
<tr>
<td>WUTH - No current issues were noted.</td>
<td></td>
</tr>
<tr>
<td>WLA – No current issues were noted.</td>
<td></td>
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</tbody>
</table>
2 Cheshire and Wirral Partnership
1 WCT

As per the serious incident reporting framework, a root cause analysis will be undertaken on the incident, the report and action plan will be monitored at the CCG SI Group.

There were 0 never events during this reporting period.

4.5 Diabetic Peer Review Paper

LQ presented the Diabetic Peer review and Action Plan paper to the committee. This paper provides an update on the publication of the final report of the National Diabetic Peer review following a visit to Wirral University Teaching Hospital Paediatric Diabetes Service. It also includes the actions agreed by Wirral University Teaching Hospital against the validated assessment undertaken by the Diabetic Peer Review Team and points for Wirral CCG to note.

LQ advised that an action plan has been completed and that the CCG have requested a copy. There has been good progress made but the CCG will continue to monitor.

SW asked if we have a plan for the termination of the contract with Four Seasons?

LQ advised that there is a plan in place and re-housing the current patients will not be a problem. LQ advised that we need to plan how we manage with regards to the media if there is a termination on contract. LQ advised that we want to make sure that Four Seasons is successful.

NK mentioned that both CT and CCG minutes discuss child health information centre which is currently commissioned by WUTH. The issue has been on the risk register for a long time but has recently come off. MG advised that there would be an update on this in the 7th October.

PN agrees with JK that this is a risk.

MG advised that WUTH and NHS England have worked alongside each other to make a workplan.

PN suggests that the committee strongly think about adding this onto the risk register for monitoring.

The committee discussed and all agreed that this will be put on the risk register and the scores where agreed as a 3 for likelihood and a 4 for consequence.

5.1 Minutes for Noting

Subgroups (ratified minutes) for noting:

- Quality Committee/Serious Incident Review Group of 09.07.2014
- CT Contract Monitoring minutes of 05.08.2014
- Quality Surveillance Group – No meetings held in August
- WUTH Quality & Clinical Risk Minutes of 30.07.2014
- WUTH Contract monitoring minutes of 31.07.2014
- Quality and Safety Review minutes of 15.08.14
- CWP CMM Minutes of 07.08.2014
<table>
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<th>Ref No.</th>
<th>Minute</th>
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<tbody>
<tr>
<td>QPF14-15/0031</td>
<td>Members of the committee noted the ratified minutes of the subgroups detailed above.</td>
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<td></td>
<td><strong>6.0 Risk Register</strong></td>
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<td></td>
<td>LW advised that action plans are in place and monitored in relation to the risks identified on the register. This will next be reviewed at Governing Body on 7th October 2014.</td>
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<tr>
<td></td>
<td>LW apologised that some risks were not showing on the front sheet of the report as there have been some formatting issues with the agenda.</td>
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<td></td>
<td><strong>7.0 Any Other Business</strong></td>
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<tr>
<td></td>
<td>There were no other items of business.</td>
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<tr>
<td></td>
<td><strong>8.0 Date and Time of next meeting</strong></td>
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<tr>
<td></td>
<td>The date and time of the next QPF meeting is scheduled for:</td>
</tr>
<tr>
<td></td>
<td>Tuesday 28th October at 1pm in Room 539 OMH</td>
</tr>
<tr>
<td></td>
<td><strong>Latest submission date for papers is Friday 17th October 2014</strong></td>
</tr>
<tr>
<td></td>
<td>Please forward any apologies to <a href="mailto:Allison.hayes@nhs.net">Allison.hayes@nhs.net</a></td>
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<tr>
<td>No.</td>
<td>Issue</td>
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<tr>
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<td>Issue 1</td>
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<td>Issue 3</td>
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<td>4</td>
<td>Issue 4</td>
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</table>

Legend:
- Probability: Almost Certain (5), Likely (4), Unlikely (2)
- Impact: Catastrophic (5), Major (4), Moderate (3)
- Rating: Yellow (Low), Green (High)
- Action Plan: To be agreed with lead.
**ACTION PLAN TEMPLATE FOR RISK No:** 12/13E  
**Title of Risk:** Lack of demand data/activity plans to forward plan future needs due to unavailability of business intelligence

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
<th>Previous Matrix Score</th>
<th>Key Control Established</th>
<th>Key Gaps in Control (reference to evidence)</th>
<th>Assurance on Controls (reference to evidence)</th>
<th>Gaps in Assurance (reference to evidence)</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Residual Risk Rating</th>
</tr>
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<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>12.00</td>
<td>SLA meeting with CSU/ business Intelligence team</td>
<td>Ability to lead contract negotiations. Ability to provide accurate national returns</td>
<td>Regular monitoring through CSU/SLA meetings. Escalation to CSU MD. Monitoring through QPF committee</td>
<td>Ability to influence behaviour. Ability to plan</td>
<td>4</td>
<td>4</td>
<td>16.00</td>
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</table>

**Monitoring of Action Plan:** Quality, Performance and Finance Committee

<table>
<thead>
<tr>
<th>Areas for Review</th>
<th>Recommendation/Action</th>
<th>Lead Person</th>
<th>Target Date for completion</th>
<th>Progress of Actions</th>
<th>Date for next Review</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closer monitoring of SLA</td>
<td>Development of Matrix: Buy, Share, Do</td>
<td>Mark Bakewell / Lorna Quigley</td>
<td>On-going Review</td>
<td>Oct 13: Review of matrix to be undertaken. TB Dec 13: National guidance has now been released to support the CCG. Initial discussions have been undertaken at Ops. Further meeting arranged to discuss further before taking to GB.</td>
<td>August 2014</td>
<td>Oct - 14</td>
</tr>
<tr>
<td>Areas for Review</td>
<td>Recommendation/Action</td>
<td>Lead Person</td>
<td>Target Date for completion</td>
<td>Progress of Actions</td>
<td>Date for next Review</td>
<td>Date of Completion</td>
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<tr>
<td>Workload and Work plan</td>
<td>Develop Work plan to prioritise CSU tasks.</td>
<td>Lorna Quigley/Mark Bakewell/CSU</td>
<td>October 2013</td>
<td>February 14: Completed review of Buy, Share, Do function of CSU. Made intentions clear to CSU, currently in discussions regarding transition.</td>
<td></td>
<td>Oct 13</td>
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<tr>
<td></td>
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<td></td>
<td>April 14: For management exit plan being implemented to bring BI in house. LQ</td>
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<td></td>
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<td></td>
<td></td>
<td>July 14: For management exit plan being implemented to bring BI in house. LQ</td>
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<td></td>
<td></td>
<td></td>
<td>August 14: For management exit plan being implemented to bring BI in house. LQ</td>
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<td>October 14: BI function is now within the CCG, transition complete from the CSU. Recommend closure.</td>
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Updated: October 2014

To be sent to GB: 11th November 2014
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<thead>
<tr>
<th>Areas for Review</th>
<th>Recommendation/Action</th>
<th>Lead Person</th>
<th>Target Date for completion</th>
<th>Progress of Actions</th>
<th>Date for next Review</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop generic e-mail address for receipt of all jobs to be entered into work plan for prioritisation.</td>
<td>Lorna Quigley/Mark Bakewell/CSU</td>
<td>October 2013</td>
<td></td>
<td></td>
<td>Oct 13</td>
</tr>
</tbody>
</table>
| Monitoring      | Continuous monitoring of the prioritisation system to ensure confidence and assurance is met. | Lorna Quigley/Mark Bakewell       | On-going                  | Nov 13: Further monitoring required.  
April 14: On-going monitoring continued. LQ  
July 14: On-going monitoring continued. LQ  
August 14: On-going monitoring continued. LQ  
October 14: On-going monitoring continued. LQ                                                                 | Decembe 2014         |                   |

**Name of Lead for Action Plan:** Lorna Quigley / Mark Bakewell

**Date:**
14th October 2013  
12th November 2013  
12th December 2013  
20th February 2014  
16th April 2014  
22nd July 2014  
27th August 2014  
30th October 2014

**Updated:** October 2014  
**To be sent to GB:** 11th November 2014
**ACTION PLAN TEMPLATE FOR RISK No: 13/14B**

**Title of Risk:** Impact of Section 251 on Data Flows impacting on ability to perform commissioning function and respective data analysis

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<th>Likelihood</th>
<th>Residual Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>12.00</td>
<td>CCG / CSU data flow arrangements have been reviewed and amended in line with requirements. CSU staff have been seconded into DMIC for appropriate data processing roles</td>
<td>100% of all dataflows in line with required guidance, staff awareness within both CCG / CSU regarding personal confidential data issues</td>
<td>Data Flow Mapping exercise as part of Information Governance Toolkit Submission</td>
<td>100% mapping to be completed and in conjunction with CSU Data flow Mapping Exercise</td>
<td>4</td>
<td>3</td>
<td>12.00</td>
</tr>
</tbody>
</table>

**Monitoring of Action Plan:** Quality, Performance and Finance Committee / Governing Body

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<tr>
<td></td>
<td>guidance.</td>
<td></td>
<td></td>
<td>July 14: CCG’s ASH Status &amp; Ceff is mitigating the risk – recommend closure – to be discussed at September GB.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance</td>
<td>Conduct data flow mapping exercise as part of Information Governance Toolkit submission.</td>
<td>Mark Bakewell</td>
<td>Oct 13</td>
<td>Oct 13: To be completed by the end of October. Further update to be provided next month. TB</td>
<td></td>
<td>November 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nov 13: Toolkit submitted. TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison with WUTH for data flows</td>
<td>Reconciliation project to be developed to agree accurate data options.</td>
<td>Lorna Quigley / Mark Bakewell</td>
<td>December 2013</td>
<td>Dec 13: Meeting held between WUTH and Wirral CCG. After much discussion it was agreed to trial a new way of working from month 9 data onwards. The CCG agreed to come up with a list of data fields that they would want to see in the monthly CDS. WUTH agreed to add these fields into the datasets and review the datasets on a regular basis until 31st March 2014.</td>
<td></td>
<td>October 2014</td>
</tr>
</tbody>
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flows have been received from the trust since month 9 and the process has been working well, there is still some work to be done configuring our local data sources based on the removal of patient identifiable fields. The data flows will be documented in the 2014/15 information schedule of the Wirral Hospital Contract.

July 14: Awaiting sign off / completion of the Hospital contract.

Oct 14: Sign off & completion of the Hospital contract completed. Recommend closure.

**Name of Lead for Action Plan:** Lorna Quigley / Mark Bakewell  
**Date:** 14th October 2013
13th November 2013
9th December 2013
20th February 2014

**Updated:** October 2014

**To be sent to GB:** 11th November 2014
**ACTION PLAN TEMPLATE FOR RISK No:** 14-15J

**Title of Risk:** Wirral CCG Care Home Provider

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</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>16.00</td>
<td>Wirral CCG Care Home Provider</td>
<td>Concerns raised regarding quality of care provided by some care home providers in Wirral.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
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<tr>
<td>Concerns raised regarding quality of care provided by some care home providers in Wirral.</td>
<td>To work closely with local organisations (Local Authority, Care Quality Commission, Healthwatch) CCG Safeguarding Team to monitor care home performance Escalation of issues required via the Cheshire Warrington &amp; Wirral Quality Surveillance Group.</td>
<td>Lorna Quigley</td>
<td>Ongoing</td>
<td>Partnership working is ongoing. Quarterly report provided to QPF committee by the Safeguarding team. Ongoing at present.</td>
<td>November 2014</td>
<td>November 2014</td>
</tr>
</tbody>
</table>

**Name of Lead for Action Plan:** Lorna Quigley  
**Date:** July 2014 August 2014

*Updated: October 2014  
To be sent to GB: 11th November 2014*
**ACTION PLAN TEMPLATE FOR RISK No:** 14-15L

**Title of Risk:** Continuing Healthcare issues re finance

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<tr>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Continuing Healthcare issues re finance</td>
<td>No financial forecast re retrospective CHC cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td>Continuing Healthcare issues re finance</td>
<td>Risk that there is no financial forecast re retrospective CHC cases.</td>
<td>Mark Bakewell</td>
<td>November 2014</td>
<td>Since the QPF Committee when it was agreed for this new risk to be included on the risk register, the CCG has received updated guidance from NHS England regarding the risk sharing agreement for current &amp; future financial</td>
<td></td>
<td>October 2014</td>
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This revised agreement will result in top slice adjustments to the CCG allocation to cover restitution claims in future financial years. As such, whilst this has been identified as an impact re availability of non-recurrent resources, the CCG is not exposed to unmitigated risks.

Recommend closure.

Name of Lead for Action Plan: Mark Bakewell  
Date: October 2014